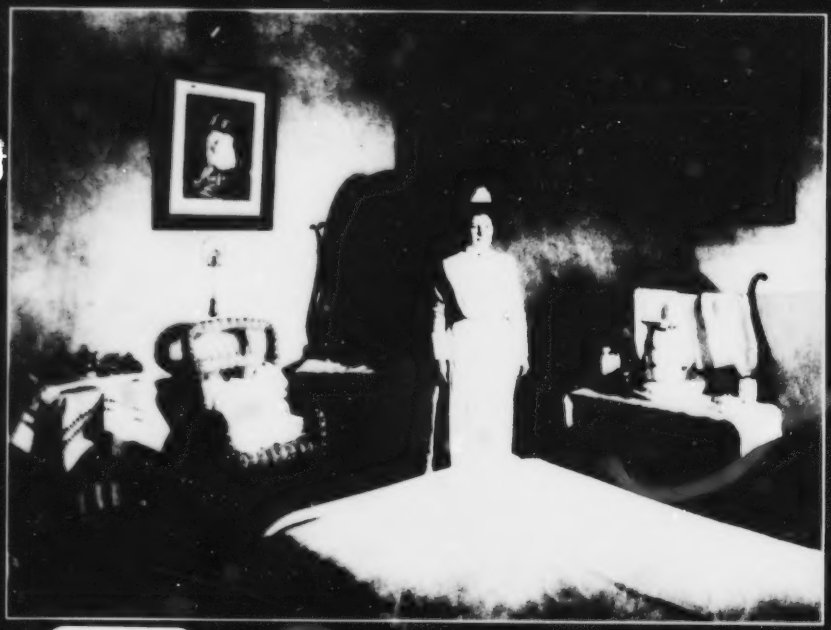
The Challenge of Caring

A History of Women and Health Care in British Columbia



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BRITISH COLUMBIA
Ministry of Health and
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Women's Health Bureau

COVER PHOTOS:
VANCOUVER GENERAL HOSPITAL PRIOR TO 1915. MINISTRY ARCHIVES.

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by Debra J. Brown

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The Challenge of Caring

A History of Women and Health Care in British Columbia

By Debra J. Brown

In British Columbia, many st:ong, determined and intelligent women have played vital roles in the formation of our province, particularly in the development and delivery of health care. Some of these contributions are documented in writings that call attention to individual issues, occupations, and organizations. There are just as many unwritten stories of bravery, innovation and knowledgeable care offered by women in the course of their daily experiences as wives, mothers, neighbours, missionaries, lay practitioners and trained health care professionals. As well as advocating for the rights of women and children, women's groups have been at the forefront of the quest for improved public health and education.

Health care is also an area in which the long-standing marginalization of women has been overwhelmingly clear. Despite women's involvement as health care workers and advocates, men customarily held the positions of power both in providing care and in planning policies that influenced health. Traditional assumptions about the different roles, temperaments and behaviours of men and women were so deeply entrenched in the consideration of both health and social issues that they became determinants of health in themselves. Our state of health, as well as our ability to achieve our full potential,

reflects the effects of the conditions in which we live and the opportunities we are permitted or denied in life. Women often suffered as a result of policies and practices implemented without adequate attention to the likely ramifications. This has been most evident in the areas of reproduction, mental health, the responses to violence against women, research into the manifestation and treatment of disease, and the delayed acceptance of women as professionals in the health care field.

This historical overview provides an opportunity to chronicle the spirit and determination of a few of the many women who perceived the biases in their society's common assumptions about women, and either worked to correct them or succeeded in spite of them. It also highlights some of the social issues in each decade and the challenges women faced as a result. How women have responded to these challenges and the consequences, in terms of both their personal health and their involvement as professionals, is enlightening in its own right. Of equal importance, this book illustrates and celebrates the vital, if often downplayed, role women have played and continue to play in the development and delivery of British Columbia's health care system. Awareness of their role is empowering to the next generation as it prepares to build on the accomplishments of the past. This history is dedicated to these women of the past, present and future.

The First Women in Health Care

The woman's role as healer, or Shaman, in what is now called British Columbia, began long before the arrival of Europeans. The role of Shaman was and still remains a calling open to both sexes. Women play an equal but different role in healing. The powers of a male healer are considered strong and consistent. The woman's powers are said to fluctuate with her monthly cycle because blood is considered a contaminant. However, she is considered potentially more powerful than a man at other times during the month. The sex of the healer is a factor in some situations. For example, male healers do not provide healing to pregnant women because their energy is thought to be too strong for the developing baby. Young apprentices learn the necessary skills and understanding from listening to and watching their elders. Skills are passed down primarily through families, but aboriginal families are "extended" in nature, which means anyone deemed worthy may be chosen for training.[1]

The arrival of Europeans brought diseases on a magnitude never experienced before by First Nations people. There was no traditional store of knowledge with which to fight them. Communicable diseases like smallpox, measles, respiratory ailments and venereal diseases decimated the native population.

In 1838, Governor James Douglas wrote that an estimated one-third of the aboriginal population on the Northern Coast had died from smallpox alone.[2] While recent studies suggest a pre-contact range in the aboriginal population numbers of between 80,000 and 125,000, the effects of disease are indisputable. By 1929, the aboriginal population of B.C. had dropped to 22,000.[3] The resulting impact of these ravaging diseases on family and community structures were

devastating and created immense hardship.[4] In European society these ailments were common and primarily affected children who had not yet developed the immunity to fight them. These diseases were completely foreign to the aboriginal population, so every age group was affected. Many leaders and healers were lost.

New leaders and healers have since emerged and the long process of rebuilding the native identity is underway. Women like **Ellen White** of Nanaimo have been at the forefront of reviving traditional languages, beliefs, and practices in an effort to restore balance and good health to the lives of her people. Trained in the healing arts from childhood, Ellen had assisted in the births of several babies before her tenth birthday. At that young age, she took on the nursing care of her chronically ill father at his request. He advised his doctor that Ellen was a trained healer and very capable of looking after him. She cared for him until he succumbed to heart disease four years later.

Growing up on a small island off the coast of Vancouver Island during the 1920s and 1930s made obtaining an education a challenge. The federal government would not accept Ellen in residential school because her family did not have "Status Indian" designation. Provincial funding was finally provided, and local children travelled by rowboat to a neighbouring island where classes were initially held in a leaky houseboat. Ellen recalls that as the tide came in, water would rise through the broken floorboards around their feet.[5] Gifted in the languages of her people and trained as a longhouse speaker, Ellen progressed quickly through school, obtaining a diploma in languages and lecturing from the University of Victoria. She has travelled widely and uses her skills to teach West Coast aboriginal history, culture and healing in college classrooms, lecture halls, longhouse meetings and private conversations.

Always crediting her elders for the wisdom they passed onto her, Ellen has continued this tradition. Almost 30 years ago she was instrumental in opening Tillicum Haus in Nanaimo as a place of

learning, healing and friendship for First Nations people. Her willingness to share her knowledge with an air of quiet pride in her heritage and her consistently proven healing ability are an inspiration to young people. One Tillicum Haus worker said of her, "...every conversation is a learning experience."[6]

The health challenges facing British Columbia's aboriginal women are many. For example, their life expectancy is currently 12 years less than for the general female population. Depression is more prevalent among aboriginal women, as is the rate of cervical cancer. Restoring the physical, mental, spiritual and emotional equilibrium necessary for well-being will require a balance between the wisdom of the elders, the strength of the young, and the cooperation and understanding of the people of British Columbia as a whole.

MINISTRY IMAGE BANK 11-185

Sharing and appreciating knowledge and experience from one generation to the next is a key component of traditional aboriginal healing.

The Early Years

1849

The colony of Vancouver Island was established and transfer of control shifted from Britain to the Hudson's Bay Company.

1858

The town of Victoria consisted of 12 houses and was protected by Fort Camosun (later named Fort Victoria). The first hospital opened on the corner of Yates and Broad Street in this year as well. The rather grandly named "Royal Hospital" was a temporary site located in a donated cottage. For the first six years, only men were admitted.[7]

1862

Victoria's first bride ship arrived from England. The cargo consisted of 60 "women" between the ages of 12 and 15 who were deemed destitute and without a future in their homeland. Sponsored by the Anglican Church, the girls made the three-month journey in complete isolation from the other passengers and were not allowed to disembark during port calls en route.[8]

1864

An infirmary for women was constructed in Victoria at the head of Pandora Street at a cost of $4,000. It was a single-story frame structure built specifically for the purpose. Many other early hospitals took over existing building space not originally intended for medical use. Four local doctors offered their services at no charge on a rotating basis. This facility also housed female psychiatric patients. A matron was hired at $25 per month plus room and board, on the understanding that she would receive her salary only when she had patients to care for.[9] Within the next few years, the men's infirmary would be amalgamated into this site.

1867

Canada became a nation, and health care became a provincial responsibility under the *Constitution Act*. Not yet a province, British Columbia was not bound by the provisions of this *Act*.

1868

Victoria became the capital of the Colony of British Columbia.

1869

An ordinance was passed to promote and upgrade health services in British Columbia. It provided a framework involving health districts, local health boards, sanitary regulations and the appointment of a provincial health officer when necessary to deal with emergencies

and epidemics.[10] From this tenuous beginning would emerge B.C.'s Public Health Service which provided women with a network of health support services as well as career opportunities.

1871

British Columbia entered Confederation as a province.

1872

The original men's infirmary, the Royal Hospital, was renovated to become the province's first asylum for psychiatric patients. Previously, only male psychiatric patients had been accepted, but both men and women were admitted from this time on.[11]

1876

In response to numerous public requests, the Sisters of Saint Ann opened St. Joseph's Hospital in Victoria. St. Joseph's was the brain child of Mother Mary Providence who undertook the project with no money but a wealth of faith and confidence that the plan would succeed. Funded entirely by donation, the hospital was a two-story structure with 35 beds, built at a cost of $13,900. Its first patient was admitted before the opening ceremonies had concluded.[12] This bustling facility expanded twice before the turn of the century. An early form of medical insurance was offered to offset the cost to patients and to assist with the hospital's operating costs.

1882

The Women's Christian Temperance Union (WCTU) opened its first B.C. branch in Victoria. While the historical reputation of this movement has generally focused on prohibition, its work in supporting women's initiatives is often overlooked. This organization and others like it provided the engine that drove the women's movement in Canada. Traditional opposition to women's initiatives was countered by organizations like the WCTU, the YWCA, missionary

St. Joseph's Hospital

societies, and various local associations, all of which supported equal access for women to higher education and career opportunities. The entry of women into the field of medicine was greatly assisted by these organizations through their promotion of medicine as a "natural outlet for a woman's nurturing nature."[13] While more accepting than the professions of law or theology, it would be some time before the Canadian medical fraternity would provide opportunities for women on the same level as that offered in the United States and Britain.

1886

Very young Chinese girls were smuggled into Victoria and Vancouver during this time for the purpose of prostitution and were badly mistreated. A rescue home for these girls was opened in Victoria by the Methodist Church and operated by women.[14]

The Canadian Pacific Railroad reached Vancouver, offering easier access for settlers and hastening the growth of the West. A tent hospital was constructed near the railroad terminus until more permanent facilities were built. In neighbouring New Westminster, St. Mary's Hospital was opened under the direction of the Sisters of Charity of Providence. This 15-bed care facility offered a unique medical insurance plan under which all medical and hospital care were covered for $10 per year. With no government funding, this insurance scheme, along with fund-raising expeditions by the Sisters to logging and railway work camps, kept the hospital open.[15]

1890–91

The Royal Jubilee Hospital opened in Victoria. A small staff of three nurses cared for an average of 40 patients on three wards.[16] Within a year, the Jubilee started the province's first nursing school. The two-year apprenticeship program attracted bright, dedicated young women who worked long hours for little pay. The first class consisted of six students who received a monthly stipend of $5 plus room and board during their first year of training. As their training progressed, this amount increased to $15 and $20 at the discretion of the hospital board. Once they graduated, nurses were paid a salary of $30 per month.[17] Four of the original six students completed the course, and two of these women received gold medals for their superior marks.

1892

Smallpox is just one example of the numerous epidemics that hit the province during these early times. In this year, Victoria suffered an outbreak that tested the mettle of medical women and men alike. In the buildings erected as isolation wards adjacent to the Royal Jubilee Hospital, caring for patients was voluntary. Medical staff and patients were quarantined together for the duration of the epidemic. **Marie Bullock Webster** was a student nurse who volunteered to care for the victims.

> We had no access to the Hospital during that time from June till December. The Quarantine Hospital consisted of rough board buildings, one long ward for men and another for women, various bath houses, tents and shacks for sleeping quarters.... Our fence was decorated with yellow flags and it was amusing to watch people drive far on the other side of the road when passing, while we were lifting and nursing all the time. Our only protection being vaccination and I think that proves its effectiveness as not one nurse or employee ever took the dread disease.[18]

Amendments to the federal laws of Canada made it an indictable offence to counsel birth control or to provide birth control information or products. Section 207 of the Criminal Code made offenders liable to two years' imprisonment.[19]

1893

Mary MacNeill was registered as the province's first female doctor and practiced in Victoria. She had received her medical training in Chicago. Women were often forced to travel to the United States for medical training because Canadian colleges frowned on female medical students and accepted only a few very determined women.

1894

Opened by the Sisters of Providence, Saint Paul's Hospital provided an impressive four-story building with a staff of seven nursing sisters to serve Vancouver residents. St. Paul's admitted 104 patients in its first year and delivered one baby. Fund raising sent the nuns up and down the coast on horseback, selling tickets entitling the bearer to free hospital and medical care. The facility expanded rapidly over the ensuing years and would boast Vancouver's first nursing school after the turn of the century.[20]

After four years of begging Victoria City Hall for help, the city's Local Council of Women chapter was granted the use of an old, run-down building that it restored as a facility for destitute and elderly women. The Council provided shelter and nursing care for women in need but was entirely dependent on donations of money, food and clothing. In 1909, accommodating the growing numbers of women in need necessitated a move to a larger building.[21]

1896

Dr. Ernest Hall began using hysterectomies and other gynaecological procedures to treat women diagnosed with emotional and mental illnesses. In his article *Gynaecological Treatment of the Insane in British Columbia*,[22] Dr. Hall cited dozens of cases of women confined to the Provincial Hospital for the Insane in Victoria for depression and dementia, and outlined the surgical procedures used to treat them. His first patient, who was suffering severe depression after the loss of a child, was "cured" by hysterectomy. Encouraged by this result, the doctor treated at least 65 other women in a similar fashion. Although his successes were admittedly few, the doctor persevered, treating a wide range of symptoms such as melancholia, religious delusions and menstrual mania. His assumption that women's mental health was tied to their reproductive system was typical of the time. This issue would resurface in the 1930s with the passage of a sexual sterilization bill and would raise serious questions about what constitutes mental illness. Interestingly, the notion of the centrality of a woman's reproduction function to her general well-being was used to curtail her education as well. It was believed that if a woman concentrated on developing her mind rather than focusing on her childbearing responsibilities, her reproductive organs would wither from disuse.

Western Canadian immigration along the CN Rail route had created many isolated settlements and solitary family homesteads that lacked medical and social supports. The hardships for women and children in these conditions were considerable. During its

organizing meetings, the Vancouver Council of Women identified the need for a Visiting Nursing Service to address the needs of these settlers. **Countess Isabel Aberdeen**, wife of the Governor General, attended the Vancouver meetings. The women's concerns meshed with ideas the Countess had heard in the Kootenays the year before about the concept of cottage hospitals.

The cottage hospital was a nursing service that provided a way of bringing medical care to remote areas. Typically based in a dwelling, nurses were available 24 hours a day to deliver babies and treat illness and injury. The Victorian Order of Nurses (VON) was already providing this type of service in England. The Countess used her influence and considerable energies to spearhead the move to bring the VON to Canada. The struggle for funding was a long one, involving a Canada-wide plea for donations. The Countess never gave up, because the need was clearly apparent to her. Of the Annual Meeting of the National Council of Women she wrote:

> ...many of the members told pathetic stories of cases where young mothers and children had died, whilst husbands and fathers were traveling many weary miles for the medical and nursing aid which might have saved them....[23]

In the same year, the Sisters of St. Joseph opened Mater Misericordiae Hospital to serve the mining community of Rossland and the workers of the smelter in nearby Trail. Within a year, the temporary facility grew under the Sisters' direction into a permanent hospital. When a mining strike threatened to ruin the hospital financially, its administrator, **Sister Teresa**, requested an annual grant from the provincial government. This was the beginning of the hospital grant system that all Canadian hospitals use today.[24]

A national organization, the Local Council of Women (LCW) began in British Columbia in 1896. Health care was a pivotal focus

from the initial organizing meetings in Vancouver, when the need for rural nursing services and cottage hospitals was identified. This meeting led to the introduction of the Victorian Order of Nurses (VON) in Canada. By the end of the 1920s, the LCW had numerous branches around the province and had contributed its expertise on a broad range of health issues. The *Victoria Times* of 1928 listed some of the reforms attributed to the LCW. Although they are too numerous to list in full, the following excerpts from the article gives an indication of their work.

> Formation of friendly help, first organized for voluntary assistance to the needy.... Worked towards obtaining home for aged and infirm women.... Organized a women's exchange during a time of financial depression.... Urged on Government the establishment of a provincial home for TB patients.... Organized a home nursing society for the benefit of those unable to pay.... Established a free maternity...in a private hospital, for mothers unable to pay.... Established and maintained an operating table in the Jubilee Hospital for minor operations on children.[25]

1898

Dr. Vera McPhee, Vancouver's first woman doctor, opened her practice in this year. Meanwhile, the Victorian Order of Nurses established its first B.C. branch in the city. A lack of available accommodation and little money made implementing this service a struggle. Within two years, however, a full-time nurse was in place with a monthly salary of $30. A free B.C. Electric Railway ticket was also provided to help her make her rounds.[26] At about this time as well, the Salvation Army opened the original Grace Hospital in Vancouver. Although it dealt with some general medical cases, the main focus of its work was maternity care for unwed mothers.

Elsewhere in the province, St. Eugene Hospital opened in Cranbrook under the direction of the Sisters of Providence. As the only source of medical care in the area, the Nursing Sisters provided general care, as well as treating victims of railway or mining accidents, epidemics and forest fires. They also instituted an independent medical insurance plan and started a nursing school that provided a source of inexpensive labour to staff the hospital, thereby reducing the financial burden on the small community.[27]

The Rush for Gold and Women's Invaluable Gift of Caring

When gold was discovered along the Fraser River, life in British Columbia changed almost overnight. To this point, the province could boast only two towns of any size—New Westminster and Victoria. As the authorized point of entry to the gold fields, Victoria's population exploded with transient miners and enterprising business people. In six years, Victoria ballooned to a city of 200 houses and a sea of tents. The scramble for gold sparked an equally urgent scramble for people and resources to meet the needs of the large and diverse flood of humanity pouring into the province. Women responded to the challenge.

Four young Sisters of St. Ann traveled from Lachine, Quebec to teach and to visit the sick. The two-month journey by train and ship took them down the east coast of North America, across the Isthmus of Panama, and finally up the West Coast on a ship that also carried 1,700 gold seekers. On arrival, they were housed in a rough log cabin with broken windows, which they covered with their aprons against the weather. The lodging provided little comfort, being without an outhouse or a well. Trained as teachers, not nurses, they soon found themselves pressed into caring for the sick out of sheer necessity. Like most young women, they had learned the basic skills of giving care while watching and helping their mothers. Within the next 20 years, the Sisters would also take it upon themselves to coordinate the construction of Victoria's first permanent hospital.

This was only the beginning of a long record of women stepping in to meet the health care needs of growing B.C. communities. As the gold rush extended into the Cariboo and settlements developed away

from the population centres, religious orders and missionaries provided much of the medical care that existed. Nuns and ministers' wives regularly filled the role of health care provider. Hospitals were hastily thrown together in shacks, often without beds or blankets. It was not uncommon for these women to take what little rest they could, curled up in sleeping bags on the floor or in equally crude accommodations. Supplies were expensive and hard to secure, and funds were typically tight.

Although women provided most of the care, men most often received it. Victoria provided an infirmary strictly for men, six years before building one for women. The reasons for this reveal a tremendous amount about the views of society at the time. Getting a physician to treat an illness or injury could be an expensive proposition. People consulted a doctor only when it was absolutely necessary. For families, the health of the husband was of primary importance. The man was the family's principal breadwinner, and his inability to work was a serious financial concern. His health warranted the cost of medical attention.

A woman's contribution to family labour, generally domestic in nature, generated little or no income and was not considered valuable.[28] Unmarried women working to support themselves were paid much less than men. They had little income with which to pay a physician, or to provide themselves with the necessary shelter and nutrition to remain healthy. Most women cared for themselves when they were sick and counted on other women for support, particularly during and after pregnancy.[29] That Victoria's doctors took turns providing care free of charge to the Women's Infirmary reflects their awareness of the reality of the time. This attitude would prevail well into the next century, until the medicalization of childbirth and women's reproductive health shifted the focus of their care from home to hospital, and various forms of public and private assistance were instituted to pay for it.[30]

Government legislation, such as the 1892 outlawing of contraception, also deeply affected women's health. Intended to both help populate the country and curb promiscuous behaviour, it effectively eliminated women's control over their reproductive lives and placed enormous burdens on their bodies as well as their minds. Before this time, it had been common practice for doctors and pharmacists to provide information and birth control devices and drugs. The impact of the new laws on the lives of women was of monumental consequence and often carried tragic results. Unable to control their own reproductive functions, women faced the inherent risks and burdens of repeated pregnancies, childbirth and many years of family care responsibilities. While affluent families could often still obtain contraceptives "under the counter" from sympathetic and enterprising pharmacists, less privileged women were left to employ cruder methods. Misinformation shared among women led to home concoctions for birth control and recipes that involved caustic ingredients such as bleach, lye and tannic acid.[31] Similarly, property laws had effectively kept women out of Canadian medical schools for part of this century because owning property was a condition of admission to university.

Nursing training was becoming a career option, but it was not an easy road either. Students and graduates both worked 12-hour shifts. Lecture classes were delivered late at night after nursing duties were finished. Nursing students were required to stand during these lectures and sometimes slept standing up during them. Pay rates were very low, which was and remains typical of female-dominated sectors of employment. The few men who undertook nursing training received higher pay. For example, at the Royal Jubilee Nursing School in Victoria, male students received double the pay rates of their female classmates by their third year of training.[32]

Pioneer Women Care Providers

There were examples of women's strength, knowledge and courage in most households in these early days. Women practiced the health care skilis they had learned from their mothers and provided a network of support for each other. The women whose contributions are touched on in this section are among the legions of those who cared for their families and communities in the absence of organized medical care. A glimpse into their experiences is offered as a tribute to the many women whose stories remain untold.

Emily Susan Branscombe Patterson– "Lay Nurse and Midwife"

Emily Susan Patterson is an example of the courageous and tireless efforts of B.C.'s early women health workers in providing care to the sick in their communities. Emily accompanied her husband to Vancouver in 1873, when he joined Hastings Mill as Supervisor. The Pattersons and their four children were members of the community's social elite, but became deeply involved in the needs of their community, both in Vancouver and later in neighbouring Moodyville. With the closest hospital an overnight trip to New Westminster, Emily's skills as a lay nurse and midwife were in great demand. Although not formally trained as a nurse, Emily used her common sense and experience to address whatever health needs arose in the absence of medical care. Acknowledged as Vancouver's first nurse, she delivered babies and treated a multitude of accidents and illnesses.[33] Accounts of her amazing experiences describe her as "...fearless in her response to suture lacerated, drunken settlers, or travel by canoe at night, from Moodyville to Point Atkinson, to tend the wife of the lighthouse keeper."[34]

Sister Frances Redmond–"Early Professional"

Frances Redmond was a formally trained nurse and midwife as well as a deaconess in the Anglican Church. After completing her education in Montreal, she travelled to Vancouver in 1887 at the request of the church, to provide nursing service and to plan the building of a hospital. Respected for her organizational skills, Sister Redmond opened St. Luke's Hospital with an adjacent nursing school within a year of her arrival. She set up public health nursing services for Vancouver, Lytton and Hope, and coordinated the delivery of nursing care to epidemic-ridden communities around the province. Her belief in caring for the whole individual led her to open a soup kitchen for the hungry in downtown Vancouver, staffed by St. Luke's Hospital workers and supplied by donations from local merchants.[35]

Sister Mary of the Conception– "Practising without a Licence"

Sister Mary of the Conception came to Victoria in 1867 as a Sister of St. Ann. Although there were several doctors practicing in Victoria at the time, the nuns were often called upon by families in need. On one such occasion, Sister Mary was called to a home where a baby was wasting away with dysentery. The doctor had not been able to cure the child, and the parents were frantic. Remembering a concoction used by her mother in treating teething troubles, Sister Mary prepared a syrup of ground pork bone, sugar and milk. She left instructions that the baby be given small doses at intervals. The child began to improve overnight and soon recovered completely. When the doctor next called on the family, he was furious that the Sister had treated the small patient without having a medical licence and tried to have her jailed. The venerable physician, J.S. Helmcken, came to the nun's aid and she was credited with saving the baby's life rather than being imprisoned for it.[36]

Aboriginal Midwives—"She Can Do Everything"

(translated from the Nuu-chah-nulth language)[37]

Although the term "midwife" has no direct translation in aboriginal languages, the term "She Can Do Everything" indicates the esteem in which aboriginal peoples held midwives. Duties varied between communities, but the women and sometimes men who assisted with childbirth were highly revered. Training involved passing down knowledge orally from generation to generation and observing elder midwives. Their approach was holistic and individualized and spanned the pregnancy period, the birthing process and postpartum care. Midwives required a deep understanding of tribal customs and language in order to guide women through pregnancy and childbirth while respecting cultural teachings regarding the causes of illness. Instructing expectant mothers in the traditional dietary and behavioural restrictions and performing ceremonial rituals were also tasks of the midwives. They used massage to reposition breech babies and used natural medicines such as herbs. Childbirth was seen as a community experience as opposed to a woman's personal travail.[38]

The Turn of the Century

1900

During the first decade of the 20th century, the population of B.C. grew from 100,000 to 393,000. Vancouver's population grew from 27,000 to 100,000 as the labour required for resource development spurred immigration.[39] Tuberculosis was the leading cause of death and accounted for 10 per cent of all fatalities. Other contagious diseases caused seven per cent of all deaths. These illnesses were of particular concern to women as primary care givers, but also because of the large numbers of their children who succumbed to disease. Twenty-five per cent of children died before the age of two.[40]

There were fewer than half a dozen women physicians in B.C. during this decade. The province's only woman dentist was even more of a novelty. *The Vancouver Province* newspaper announced the arrival of **Dr. Florence McAlpine,** the first female graduate of the St. Louis Dental College, who passed the B.C. Dental Association qualifying examination with highest honours.[41]

St. Joseph's Hospital in Victoria established a school of nursing, under the direction of **Sister Mary Gertrude of Jesus,** a Sister of St. Ann. With no funds available for textbooks, she created a course of studies based on her considerable experience in the medical field. In fact, her knowledge was said to be equal to the practicing doctors of the day. When she retired 12 years later, no one person was proficient enough to replace her. It became necessary to divide her lectures among several doctors.[42]

The Queen Victoria Hospital was opened in Vernon by the Victorian Order of Nurses (VON). A cottage hospital, it was staffed by

two nurses who also offered district nursing services. This was of great assistance to the local doctor, who to this point had relied on his wife to fulfil these duties.[43] During the two decades between 1900 and 1920, the VON established 38 cottage hospitals in rural areas of the province, maintaining a medical presence until communities grew to the point of supporting their own hospitals. By 1922, only two of the original cottage hospitals remained under VON supervision, and public health nurses were taking over in rural settings. The organization then refocused its efforts on the role of visiting nurse in urban areas.

1904

The Women's Christian Temperance Union (WCTU) opened a home for "friendless" convalescent women in Victoria. Thirteen years of planning and fund raising had gone into the project, during which time the WCTU had assisted poor solitary women as best they could. At the opening ceremony, a speech by Victoria's Mayor, reported in *The Colonist*, demonstrated how low a priority the care of impoverished women had been to the city.

> ...[The Mayor] expressed his surprise at the extent of the work which for so long a time had, almost unknown to the public, been so successfully carried on and heartily congratulated the society on the home their efforts have secured in the interests of the friendless women of this province.[44]

1906

In Vancouver, rebuilding efforts after the fire of 1886 had involved first a tent hospital and then a more permanent structure built by the CPR. Increasing need prompted planning of the Vancouver General Hospital. Vancouver General opened its permanent site in 1906, and patients were moved from the old City Hospital. Within a year, isolation

Nurses in operating room at Vancouver General Hospital, prior to 1915.

tents for patients with diphtheria, tuberculosis, scarlet fever and other contagious diseases were set up on the hospital grounds. A marvellous improvement over the original nine-bed tent facility erected in 1886 to treat railway workers, Vancouver General would continue to expand until, in the 1990s, it would become Canada's second largest hospital, boasting four sites and treating 116,000 patients annually.[45]

1907

Fourteen women were enrolled in Vancouver's first nursing school at St. Paul's Hospital. Vancouver's need for nursing services was growing and, accordingly, the Victorian Order of Nurses had expanded to a staff of three nurses with an annual grant of $600 from the city.[46]

Caring and Coping with Grim Realities

The story of Isobel Roger and her family, preserved in the Esquimalt Municipal Archives, offers a touching chronicle of the grim realities of helplessness and loss experienced by parents whose children fell victim to disease in B.C. in the early years of the 20th century.

Isobel Roger and her family came to Canada from Scotland in 1908 with their nine children, who ranged in age from three months to 16 years. Most of the family's possessions had been sold to cover a down payment toward the cost of their travel. They arrived in Montreal destined for Victoria, with four dollars to their name. The trip across Canada took six days by rail.

In Victoria, Isobel's family moved into what remained of a shack in a camping park. Only three of its four walls were still standing, and a roof had to be fashioned out of lumber scavenged from another dilapidated shack. Isobel hung a curtain across the opening where the fourth wall should have been. When she bathed the baby, her older children would stand in a semicircle as a windbreak while she washed him in a bucket on the stove. Two tents served as sleeping quarters for most of the family.

Her husband was a gardener, and he found work immediately. Their two eldest children found jobs to supplement his income, and they were then able to afford more permanent lodgings. Unemployment was high, however, and jobs were never secure. Her husband was let go twice: the first time when employees making over $10 per week were fired in favour of cheaper Asian labour, and the second time when employees living more than 10 miles away from work were laid off. From then on, he worked part-time for the City of Victoria, maintaining boulevards.

Isobel bore her lot with good grace while caring for her six youngest children, assisted by her daughter Effie, who was 11. One and a half years later, Effie fell ill with influenza. Isobel nursed her daughter at home, but eventually Effie was taken into hospital. The contagious nature of her illness required that she be isolated. Her bed was located in a cold and draughty sunroom. Little could be done to save her, so Isobel and her husband alternated in a weary bedside vigil. The night Effie died was described heartbreakingly by her mother.

> I will never forget that night as long as I live. My daughter never got one minute's rest. We did all we could to make her comfortable—she was so restless...about four in the morning she asked me to bring the nurse. When the nurse came she said, "Mother, get Miss Noble a chair, she must be tired, she works so hard." Nurse nearly broke down when she heard that. Then she said, "Hold me Mother"...then she was at rest, at 5 a.m., 20th of June, 1910; my wedding anniversary and the day before her 13th birthday....[4]

Isobel's life is typical of many women at the turn of the century in B.C. Her family worked hard but remained poor, and the labour practices of the day kept them that way. Isobel endured repeated pregnancies and constant childcare responsibilities that added to her physical and emotional burdens as well to the family's financial ones. Birth control information and contraceptives were illegal and home methods unreliable. The education of her three eldest children was cut short because they were needed to supplement family income and assist with childcare duties. Isobel's world was limited by responsibility to the nuclear family. Her family's world was limited by social conditions that offered them few life chances.

The "Teen" Years (1910-1920)

1910

The Vancouver Graduate Nurses Association began a struggle for recognition as a registered profession that would take eight years to achieve. Registered status would give nurses the legal right to set standards and establish training requirements. Before this time, many nurses had been trained through correspondence schools in the United States or by means of on-the-job apprenticeship with no standardization. Requiring the permission of the provincial legislature, registration was delayed first by government preoccupation with World War I and then by wrangling over the definition of what constituted "nursing," as opposed to traditional care in the home performed by women. The question of whether or not doctors should have control over the nursing profession was a major issue as well. Passage of the *Nurses Registration Act* in 1918 would result in shifting the control of nursing from the male-dominated medical profession into the hands of graduate nurses who were, with few exceptions, women.[48]

While growth in terms of professional acknowledgment moved slowly, growth in nurses' workloads expanded rapidly. Within the space of a few years, the Victorian Order of Nurses established branches in Victoria, Burnaby, North Vancouver and on Saltspring Island, as well as an emergency hospital in Chase.

1912

Around 1912, a Victoria woman, **Mrs. Alfred Watt**, formed the Women's Institute to improve the living conditions and opportunities of rural women in B.C. The Ministry of Agriculture provided a

grant to help with administration costs. From two small original rural assemblies, the Institute grew to 73 branches around the province by 1920. Eventually the movement became a worldwide organization with affiliates throughout the United States, Europe, Africa, Asia, India, Australia and New Zealand. Some of the group's areas of activity included agriculture, citizenship, home economics, handicrafts, industries and social welfare.[49] Health issues were of prime importance. During the 1920s, resolutions called for properly qualified health nurses, establishment of health centres, improved TB inspection and federal government spending in health care.

1913

The provincial government appointed **Miss Blanche Swan** as B.C.'s first provincial school nurse, a major step toward improving health services.[50]

Four Sisters of St. Joseph opened the Comox Valley's first hospital in an eight-room farmhouse. Originally intended to care for local loggers, this facility soon grew to meet the needs of the Comox military training facility during World War I and the victims of the Spanish Influenza pandemic in 1918.[51]

1914

World War I began. Many of B.C.'s nurses volunteered for service and went overseas to care for the wounded.

1915

A report that nearly 29 per cent of the Canadian Expeditionary Force in Europe was infected with venereal disease brought this problem out of the shadows into the public health forum. Military officials claimed that 25 per cent of these cases were infected in Canada. Doctors generally believed that deviant women spread these diseases. This male bias would shape the policies instituted for controlling venereal disease for decades to come. Prostitutes and women

considered of "weak moral character" were targeted rather than the men who sought their company.[52]

1917

White women were given the right to vote in B.C. provincial elections, but it would be 1947 before people of Japanese, East Indian and Chinese descent were enfranchised. Aboriginal women and men waited until 1949 for this right. Another provincial legislative milestone was the *Equal Guardianship of Infants Act.* A first in Canada, this radical departure from the thinking of the day acknowledged that mothers had the same rights regarding their children within a marriage as fathers. Before this, a man could plan and carry out arrangements for his children without consulting his wife, because her wishes were legally irrelevant. This change was accomplished largely due to the efforts of **Helen Gregory MacGill**, who had just been appointed Canada's first female judge and who presided over Vancouver's Juvenile Court. In the coming decades, a woman's right to share in decisions regarding her children would evolve into the belief that she had equal and even preferred guardianship rights as a single mother over that of a single father.[53]

1918

Mary Ellen Smith became the first woman elected to the B.C. Legislature. A long-time activist for women and children's rights, Mary Ellen Smith won an overwhelming electoral victory and sat in the Legislature for ten years. She also became the first woman Cabinet Minister in the British Empire, although she sat without a portfolio. She was responsible for the Female Minimum Wage Act and the Maintenance of Deserted Wives Act.[54]

The provincial government also passed the Nursing Registration Act, giving nurses considerable control over their own training and membership. Graduate Nurses Association President, **Helen Randall,** became the first registrar of the Registered Nurses

Association of B.C. She worked tirelessly to develop high training standards and improve working conditions for nurses until her retirement from the field in 1941.

1919

A pandemic of Spanish influenza engulfed the world and graphically demonstrated the need for increased public health resources. A virulent epidemic, it took the lives of more than 50 million people worldwide and 50,000 in Canada. The only treatment was easing the effects of the symptoms, which required constant nursing care.

The Canadian Red Cross Society funded the first nursing degree program in the British Empire, at the University of British Columbia.

The Red Cross also sponsored the Empire's first diploma program for public health nurses at UBC. Originally 14 weeks in length, the program was offered to registered nurses only. The course soon lengthened to a full year and by 1923 became an optional sixth year in the Nursing Degree Program. Within three years, B.C. would have a force of 56 specially trained public health nurses, all graduates of the UBC Diploma Program.

The Fight Begins for Legitimacy of "Women's Work" in Health Care

Tremendous strides were made in the expansion of public health services during this decade. The women's movement was a strong influence in this development. Local Councils of Women, along with the Women's Christian Temperance Union and various other women's associations, were deeply involved in improving conditions for women and children. The increasing numbers of trained nurses made them a more visible part of the emerging public health system in the community. At the turn of the century, there had been fewer than 300 trained nurses in Canada. By the end of World War I there were close to 20,000 nursing graduates and students, almost all of whom were women.[55] By 1920, nursing services were being introduced into the schools, and the Victorian Order of Nurses was evident in communities, visiting homes and providing training such as Well Baby clinics for new mothers. People's faith in the scientific approach to medicine had led to increased use of hospitals and a need for large numbers of trained nurses as well. At Vancouver General Hospital in 1905, a nursing staff of five graduates and 25 students cared for up to 50 patients. By 1920, the nursing staff had grown to 45 graduates and 196 students caring for more than 1,200 patients per day.[56]

From within nursing, efforts were being made to recognize women as health care professionals. Traditionally, caregiving was seen as part of a woman's natural role. Skills and knowledge were passed from mother to daughter and became part of a woman's unpaid duties as wife and mother. Giving care in others' homes usually went along with helping do the patient's domestic chores,

and neither was considered skilled labour. The emergence of nurses' training programs in hospitals and organizations like the Victorian Order of Nurses began to change this perception. Nursing was moving out of the private sphere into the public realm and becoming recognized as a form of paid work. As the numbers of trained nurses increased, so did their desire to be recognized as a legitimate group of skilled practitioners. In addition, nurses had distinguished themselves in war duty and in the influenza pandemic of 1918-19. Their goal was not achieved easily, however. Gender biases were at the core of resistance and would prove difficult to overcome. While the male-dominated medical profession had made great strides in improving its status, the female-dominated nursing profession had not.

In what the press would dub "that disturber of legislative calm,"[57] the *Nurses Registration Act* would encounter much opposition and undergo considerable revision before its passage. Inspired by Dr. Helen McMurchie's call to regulate standards of nurses' training in 1909, the Graduate Nurses Association of B.C. (GNABC) organized themselves and responded to her concerns by 1912. To this point, nursing qualifications had been available in a variety of ways; by correspondence from the United States as well as through numerous hospital nursing schools with no established standards. Consequently, there was great inconsistency in knowledge and skill levels. The nurses' plan was to form a 12-member examination board comprising two doctors and representatives elected from the GNABC. The presentation of a *Nurses Registration Bill* to the legislature was delayed by the start of World War I. The war raged on and many nurses served in that cause.

At the same time, efforts to secure the vote for women led to an affiliation between the GNABC and the Vancouver and Victoria chapters of the National Council of Women (NCW). The NCW struck a standing committee "...to work for the improvement of nurses' education, the elimination of exploitation and the attraction of better recruits."[58]

The *Nurses Registration Bill* was finally presented to the legislature in 1916. Although it was similar in nature to the acts governing the medical and legal professions, concern was raised about the degree of autonomy the nurses would have in governing their members. It was felt that doctors should have a greater say in decisions about the nursing profession. Nurses were, after all, expected to defer to doctors. There was also opposition on the grounds that if nursing standards were too high, their services would not be affordable. This issue was raised despite the fact that the medical profession was in the process of increasing its own educational requirements. Some nursing course work, like bacteriology, was challenged as being in the domain of doctors alone. Prejudices also emerged, going back to the days when women were expected to nurse in the course of their daily "womanly duties." The suggestion was made that family members no longer be allowed to care for sick relatives without professional training.[59]

With the accomplishment of women's suffrage, however, a new atmosphere led to the acceptance of Bill 68, the *Nurses Registration Act* that became law in 1918. Although weakened from its original form, it was a basis for professional legitimacy. Acknowledgment of nursing as a profession, however, would not come until a 1930 report on nursing, jointly commissioned by the Canadian Medical Association and the Canadian Nursing Association.

B.C. Nurses Abroad and on the Home Front

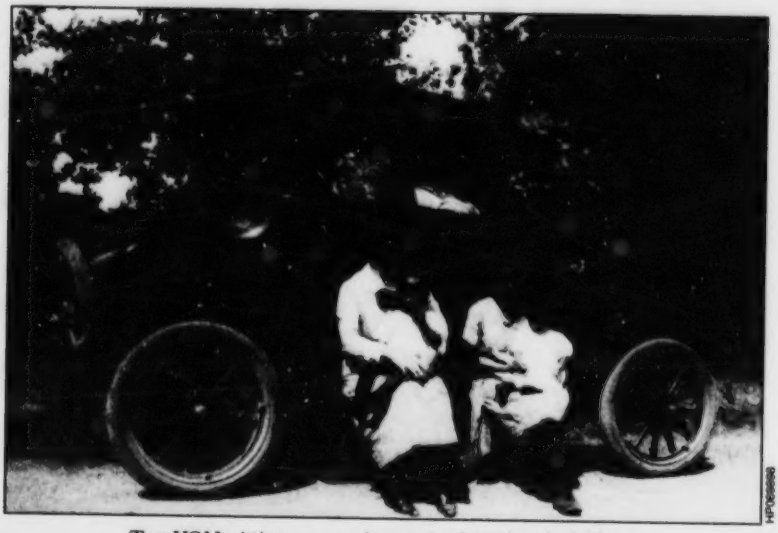
British Columbia contributed its share of nurses to the war effort, several of whom did not return. One of these was **Nursing Sister Gladys Maude Mary Wake.** Gladys was born in Esquimalt in 1883. Her family lived there for many years, but was residing in England when World War I broke out. By then a trained nurse, Gladys volunteered her services and in 1916 was appointed a Nursing Sister in the Canadian Expeditionary Force. She served in several hos-

pitals over the next two years. Several days after her posting to the Canadian General Hospital in the French fishing village of Etaples in 1918, Gladys suffered mortal injuries during a two-hour bombing raid by German fighter planes. Witnesses say that during the extended raid, one bomber used the bright moonlight and the flames from the rubble to spot both patients and medical staff in the hospital debris, and fired on them repeatedly. Throughout the ordeal, nurses and attendants continued to scurry to the aid of the wounded.[60]

Eighty years later, in 1998, Gladys was honoured for her sacrifice by the Province of British Columbia. Through the efforts of an Esquimalt historian, Sherri Robinson, Mount Wake was named in Gladys' memory under a B.C. Ministry of Environment, Lands and Parks program that names previously unidentified geographical features in honour of those who gave their lives serving Canada during times of war. Gladys is also remembered with a plaque in St. Paul's Anglican Church in Esquimalt, the church her family attended while living there.

The war interrupted the expansion of nursing services in the province. Before 1914, efforts were made to improve the health of families, and priority was given to improving children's health. In response to the *School Inspection Act of 1911,* **Miss Swan** was appointed the province's first school nurse. Working from Victoria, she was responsible for coordinating the new health program and travelled the province consulting with medical inspectors. Over the next few years, this would lead to the hiring of school nurses around the province in an effort to control infectious disease and improve the general health of children. Their duties included the annual inspection of pupils in schools, follow-ups of absentees, teaching healthy practices to families and maintaining health records. This was a major step in the development of the profession of public health nursing.[61]

After the War, public attention returned to the growing health needs of B.C.'s expanding population. In 1919, B.C.'s first public health nurse was appointed at Saanich near Victoria. **Miss Jessie Foreshaw** became the first of what would rapidly become a province-wide public health nursing service. The Department of Education soon recognized the importance of this position and provided communities with the same grant to hire a school nurse that it provided to hire a teacher. This, in addition to Health Department grants, allowed the province's smaller communities to afford public health nursing as well as school nursing services. Duties included public health clinics, annual exams for school children and follow-up visits, in-home visits to all new babies, Well Baby clinics and at-home care. While the funding may have paid a nurse's salary, it did not cover her costs. Community donations were often relied upon to provide working space and transportation.[62]



Two VONs sitting on a car's running board with children.

The Twenties

1920

The Red Cross Society provided funding to the Provincial Health Branch to develop public health nursing that would supplement existing services. The Red Cross also provided funding for a Chair of Public Health at UBC to address the desperate shortage of trained public health nurses required to meet the growing needs of the province. Eight nurses were provided to isolated areas, and nurses also visited lighthouses annually. Tuberculosis control became an important part of the public health nurse's caseload, as the disease remained a major health problem. Although active cases were admitted to provincial TB hospitals for treatment and containment of the disease, some patients deemed suitable for home care were returned to their communities where local public health nurses cared for them.

The municipality of Saanich granted $25,000 toward the construction of the province's first health centre.[63] In addition to an operating room and a four-bed hospital ward, the Saanich War Memorial Health Centre provided a base for public health nursing services that served 12,000 residents and provided practical experience for students of the new Public Health Nursing Program at UBC. It was operated under the direction of the Victorian Order of Nurses and included a Nurse Superintendent, school and district nurses, and two or three public health nursing students. Dental care was offered as well as medical care.[64]

Lillian Fowler became the first woman physician on staff at Vancouver General Hospital as an anesthetist. She received her training in Chicago and served for two years in Portland before coming to B.C. She remained at Vancouver General for 25 years and was honoured by becoming the first woman appointed to the hospital's consulting staff after her retirement.

1923

A speech by American birth-control activist **Margaret Sanger** drew an audience of 350 people to the Women's Building in Vancouver. The meeting was sponsored by the Women's International League for Peace and Freedom, and the Trades and Labour Council. The former was a left-wing political group and the latter was an organization of working women led by feminist activist Helena Gutteridge. The evening sparked considerable interest and prompted formation of the Canadian Birth Control League. This group was not in the business of distributing contraceptives, but focused on birth-control education instead. Their concerns were defined as "...first, good breeding; second, women's health; and third, a woman's right to contraceptive knowledge."[66]

1924

Of the 646 physicians registered to practice with the B.C. College of Physicians and Surgeons, only six were women. Despite such a tiny minority, by the end of the decade the minutes of the British Columbia Medical Association began making mention of "himself or herself" in reference to its membership.[67]

1925

The Women's Institute is a civic-minded organization that initiated many health programs during this decade. The Victoria branch began in this year under the leadership of **Evangeline MacLachlan** and was involved in starting a Well Baby clinic, the South Saanich Anti-Tuberculosis Society and a province-wide dental service for children. It also started a building fund to raise money toward construction of a hospital for disabled children. By 1927, this fund would enable both the Vancouver Crippled Children's Hospital and the Queen Victoria Solarium in Victoria to become realities.[68]

1927

In 1927, a Royal Commission on Mental Hygiene gave three reasons for supporting sterilization. First, there was an economic imperative to reduce the rising numbers of inmates in institutions. Second, sterilization provided a solution to what was perceived to be the largely hereditary nature of mental problems. Finally, it was a form of controlling the "abnormal" for their own sakes as well as that of the community at large.[69]

Women played a major role in shaping public opinion on this issue. Writers in a prominent feminist publication, *Western Women's Weekly*, told readers that the "feebleminded" came principally from "the poverty stricken, criminal and degenerate classes" and particularly females who were a "social and moral menace."[70] Support from women's groups was widespread and included prominent voices such as Nelly McClung, Judge Helen Gregory McGill and

MLA Mrs. M.E. Smith. There was a racial as well as a class bias to their argument as Mrs. Smith revealed in this quote:

> ...if this (sterilization) were done, the English speaking peoples would maintain their position of supremacy on which the peace and prosperity of the world depend.[71]

The medical profession also supported the movement in B.C. During the 1920s, the school medical inspection program had used IQ Tests to assess children's mental fitness. A version of the Binet-Simon IQ test, based on a criterion of "normal" established by white middle-class life experience, was used to assess children from a variety of backgrounds. Many "subnormal" children were identified among the less affluent and immigrant populations who were no less intelligent, but lacked the understanding of middle-class life experience required to score well on the tests. Poor test results supported the notion that low-income and immigrant families produced less intelligent children.[72]

1928

The Salvation Army's Grace Hospital opened its new facility on Heather Street in Vancouver. It was a hospital for women that focused on obstetrics and gynaecology. Although women of all financial circumstances were attracted by the quality of care at this facility, unwed mothers remained an important focus for this hospital.

1929

Women were legally declared "persons." In the "Persons Case," the Supreme Court of Canada determined that the *British North America Act* did not recognize women as persons. This made them ineligible to sit as senators in the government's upper house. At that time, appeals of Supreme Court rulings could be made to the high court in Britain. The British Privy Council overturned Canada's Supreme Court ruling and women achieved status as persons.[73]

One of British Columbia's most revered physicians, New Westminster native **Ethlyn Trapp**, began her practice in this year. Dr. Trapp was a specialist in radiology in an era when few women practiced even general medicine. Small in stature but mighty in deed, she was on the cutting edge of cancer treatment. She worked tirelessly and used much of her own money to set up a cancer treatment facility that employed x-rays and radiation as forms of treatment before they were accepted in mainstream Canadian hospitals. She was forced to carry on her pioneering work outside the established hospital setting for much of her career. Persistence proved her correct, and the use of x-ray and radium therapy became accepted medical practice. Dr. Trapp received many honours in her lifetime. She became the first woman president of the B.C. Medical Association in 1946. In 1952, she was the first woman to deliver the prestigious Osler Lecture at a time when women were not invited to attend, let alone speak. She was an executive member of many organizations and had several honourary degrees conferred upon her. The crowning honour was received in 1968 when she was awarded the Governor General's Medal of Service of the Order of Canada. Service was indeed at the centre of Dr. Trapp's life activities and continued even after her death in 1972. She willed her extensive art collection to galleries and left her beautiful garden property to the community of North Vancouver to be used as a park.

The Sisters of Charity opened a foundling home in Vancouver that expanded into a home for unwed mothers. This facility would later become St. Vincent's Hospital.

Changing Perspectives

The 1920s brought a major change in the public's perception of health matters. A paradigm shift was occurring from personal to professional control over the population's health care.

Ethlyn Trapp receiving Governor General's Award.

The support system women had traditionally shared with each other through family and community was being eroded by the transient nature of the population in a growing society. Taking its place were members of a chiefly male medical profession whose obstetrical training could be as brief as a two-month internship on a maternity ward.[74] The opinions of these professionals carried sway over traditional maternal caregivers such as midwives. The prevalent medical assessment of midwifery was negative, considering it "...an outdated occupation belonging to the 'dark ages' and unnecessary in an 'up-to-date' country such as Canada."[75] As doctors' assistants, nurses were seen as superior to midwives, who had no legal status as medical practitioners. Interestingly, nurses were not provided with

much maternity training, as one Vancouver General Hospital Nursing Superintendent complained at the time.

> ...nurses are given very inadequate maternity training so far as the technique of delivery is concerned. We are warned on no account to take a case without a doctor, and with our training we are not likely to do so.... We make an attractive setting for a good obstetrician and an unwilling and critical collaborator with a poor one. The medical profession is responsible for this condition. They do not fear the competition of the nurse in any other department of medicine.[76]

At the same time, high maternal mortality in the province was causing great concern because B.C. had one of the highest rates in the country.[77] Families were becoming increasingly fearful of the birthing process. The desire for safer deliveries led to hospitalization for those who could not afford the higher fees for a doctor's attendance at home, as well as the cost of private nursing care. Whether or not the shift to hospital births led to a decrease in maternal mortality is questionable. These rates did begin to drop in the 1930s, but the increased use of hospitals for childbirth came well before the decrease in maternal deaths, providing no basis for correlation.[78] It is quite possible that the improved general health of the population played a major role.

While affluent women could still afford the best of attendant care at home or in private hospitals, the majority of the population could not. Most had to rely on the Victorian Order of Nurses, or line up for prenatal care at hospital outpatient clinics and at the less expensive public wards for delivery.[79] The maternity wards at Vancouver General Hospital were overcrowded to the point where "...(the) facilities were not capable of coping with the work."[80] A maternity building was built in 1929, but conditions did not appear to improve appreciably. One head nurse complained:

> That maternity building...my goodness, you ran your feet off.... It was very cheaply built, you know.... You could hear every sound. You could be in a private room and hear every cough and sneeze above and below you.... The plumbing made so much noise and the hot water pipes cracked in the night....[81]

Two royal commissions into health insurance and maternity benefits were conducted during this decade. Sixty-nine women's groups united in a call for benefits to be paid in cash to pregnant women of all classes, whether married or not, in order to increase their consumer power and control over how and where their babies would be delivered. There was also a call from the medical profession to increase the overall quality of hospital care. These efforts were hampered by the Depression, which resulted in budget cutbacks by all levels of government.[82]

The Thirties

1930

The Red Cross assumed responsibility for the Outpost Hospital in Pouce Coupe, southeast of Fort St. John. Staffed by a matron, three nurses, a cook, a laundress and a janitor, the facility provided 22 beds. It served the community under Red Cross direction until 1935, when the community took it over. This was the first of 18 hospitals and nursing stations run by the Red Cross in response to requests from small isolated pockets of settlements around the province. These nurses provided a vital medical link between local people and the distant doctors and hospitals of the larger centres.[83] During this decade, a generalized approach to nursing emerged. Rather than having a school nurse and a community nurse, duties were divided geographically to provide continuity.[84]

1932

In this year there were 779 physicians registered to practice in British Columbia through the B.C. College of Physicians and Surgeons. Seventeen of them were women.[85]

Vancouver's maverick mayor, Dr. Lyle Telford, opened a birth control clinic for the purpose of "...better marriages, wanted children, freedom for women, and race improvement."[86] Dr. Telford operated the clinic with a nurse out of a private office in the Marine Building in downtown Vancouver until 1935, and then it moved from one location to another until 1956.[87]

1933

In 1933, a sexual sterilization bill was passed by the British Columbia legislature with little resistance. A board comprising a judge, a psychiatrist and a social worker reviewed cases presented for

consideration by mental institutions. The actual number of people sterilized in B.C. is unknown, but estimates suggest it was in the hundreds. One study determined that the program was definitely focused toward women. Of 64 cases reviewed, only 7 were men. Of the 57 women sterilized, 46 were single women, 33 of whom had borne illegitimate children. The profile of the typical case emerged as that of a young unwed mother labelled "mentally retarded" as a result of her sexual promiscuity or family background. The reasons stated for the diagnoses of retardation in the study bear this out. They included "...incarcerated kin, ...siblings seen at Child Guidance Clinics, ...cases of incest suicide, and ...family history not good."[88]

The public apparently supported sterilizing women, but performing the procedure on men was another story. One official at the Essondale psychiatric facility during this period wrote to a colleague, "People do not seem to object to [sterilizing women] at all but when sterilization for males comes up there is quite a stir."[89]

Although the permission of individuals or their guardians was required, sterilization generally offered the only means of release from a mental institution.[90] This in itself may have provided the incentive for consent, and today might be termed coercion.

1935

The tiny community of Cecil Lake opened an outpost hospital in a one-and-a-half storey log structure named Gough Lake Memorial Hospital. The hospital operated with two Red Cross nurses until 1943, when the staff was reduced to just one. Cecil Lake provides an excellent example of the dedication and community involvement demonstrated by outpost nurses in remote communities. Nurse **E.M. Claxton** held the fort with monthly visits by a minister from Fort St. John as her only outside support. Her experience is described later in this book in greater detail.

Red Cross Cottage Hospital at Bamfield

1936

The Women's Labour League sent out a petition calling for birth control clinics in the province. Its opening statement sums up the plight of working mothers in these Depression-weary years.

> ...With the widespread unemployment, the burden of caring for the home and children falls principally upon the shoulders of the working-class mothers who oftentimes, rather than bring other children into the world, with small prospects of proper food, clothing and attention, resort to the most crude and dangerous means in order to procure abortions, with all its widespread evils, as thousands of women are suffering due to the lack of proper knowledge of Birth Control....[91]

The petition was supported in the Legislature by the only two women MLAs of the decade, **Laura Jamieson** and **Dorothy Steeves**, as well as by Dr. Telford, all of whom were members of the Co-operative Commonwealth Federation (CCF).

1937

MLA **Dorothy Steeves** continued to call for free dissemination of birth control information and supplies by public health nurses, particularly in rural areas and for women on relief. She scoffed at the idea that it would prompt an increase in immorality. She pointed out that 8.5 per cent of Canadian births were illegitimate and suggested that this proved "...it is the lack of birth control information that leads to immorality."[92]

Red Cross outpost hospitals opened in Kyuquot and McBride. At opposite sides of the province, these two small communities were in great need of readily available medical services because of their remoteness and hazardous accessibility. The citizens of both towns rallied around the nurses to build hospital facilities. Kyuquot is a small fishing, trapping and logging settlement on the West Coast of Vancouver Island, while McBride is located on the CN Rail line between Prince George and the Alberta border. Government funding supplemented the efforts of both communities and allowed them to establish small hospital facilities, each staffed by two nurses. The Kyuquot facility served a population of 80, which expanded to 300 people during the fishing season. The nurses were provided with a secondhand rowboat for transportation. This hospital is still in operation today. The McBride hospital underwent numerous expansions and was turned over to the community in 1954.[93] Two additional Red Cross outpost hospitals were opened in Bamfield and Zeballos on Vancouver Island.

Also during this period, the Victorian Order of Nurses expanded its service into Surrey and Elphinstone, further increasing health services to rural areas. The Sisters of Charity of the Immaculate Conception addressed the growing urban needs for care by opening St. Vincent's Hospital in Vancouver as well.

1939

World War II began. Women contributed to health care during the war in a multitude of ways. A few women served as doctors in military facilities in Canada, but many others served as nurses, occupational therapists, physiotherapists, dietitians and Red Cross support workers at home and abroad. There were also "home sisters" who looked after the needs of nurses in the field hospitals. Women in Canada kept the wheels of industry turning and voluntarily put together "ditty bags" containing personal items of comfort that were distributed to injured soldiers.[94]

Vivian Dowdings, One-Woman Travelling Birth Control Campaign

Despite the legal barriers, women sought, through whatever means, to escape the repeated pregnancies they faced. Strong proponents of both socialist politics and the women's movement, like **Mary Ellen Smith**, among others, had been calling for birth control clinics to provide education and contraceptives. MLAs Dorothy Steeves and Laura Jamieson also took up this cause in the Legislature in the late 1930s. Interestingly, although the birth control movement did not attract the broad vocal support from women that suffrage had, women were quietly finding ways to circumvent the 1892 legislation. As researcher Mary Bishop noted:

> ...by abstinence, by contraception, by induced abortion, even infanticide, the crude birth rate had been declining.... Those who had no knowledge of contraception, or whose attempts at contraception failed, often risked their lives through self-induced abortions or visits to illegal practitioners. Some women died.[95]

At least 139 women died during the 1930s of complications from abortions.[96] This number is undoubtedly conservative, as abortion

deaths were not always reported as such. Understandably, doctors feared prosecution and families wanted to avoid being implicated in a crime as well as the social stigma associated with the procedure. Women's organizations such as the Women's Labour League, the Women's International League for Peace and Freedom, and the Council of Women called for legalization of birth control. Into the midst of this environment walked **Vivian Dowding,**[97] a birth control activist who was not deterred by the legalities against sharing birth control information and providing the means to prevent pregnancy. Mary Bishop recorded Vivian's fascinating story.[98]

Vivian was a field worker for the Parents' Information Bureau, an Ontario-based organization backed by a wealthy industrialist named A.R. Kaufman. Kaufman's well-researched program involved providing birth control information during a home visit, followed by sending safe, simple contraceptives by mail. The bureau encouraged donations to pay for repeated shipments, but those who could not afford the suggested fee of two dollars received the contraceptives free of charge. Vivian spent seven summers driving the back roads of B.C., providing birth control information and a means of obtaining contraceptives for women in small towns and camps. This was not a door-to-door campaign. Visits were based on referrals from community doctors. Vivian discovered that the doctors themselves were often in need of birth control information, because it was not a subject taught in medical school. Having herself experienced the trauma of unexpected pregnancy due to unsuccessful homemade birth control methods, Vivian had an empathetic approach that women welcomed and they often referred their friends and neighbours to her.

Active in other aspects of the birth control movement as well, Vivian consulted on the writing of a book to assist parents in teaching their children about reproduction and was also a strong proponent of vasectomy. Men had to travel to the United States for this procedure

until 1963, when she began referring dozens of clients per month to a North Vancouver doctor who had added vasectomies to his practice.

Amazing as it seems today, it was 1968 before birth control counselling and contraception were decriminalized and 1988 before women had access to legal abortions. Despite legalization, the right of women ontrol their own reproductive function remains a highly charged issue.

The Forties

1940

In the Legislature, birth control remained an issue and was complicated by the fact that B.C. had the lowest birth rate in the country. Liberal MLA J.J. Gillis charged that birth control was the reason for the unsatisfactory population numbers. CCF member Dorothy Steeves pointed to the lack of social supports for families as the cause for dropping birth rates.

> As long as you won't give people security and the means to properly look after children, you can't expect women to bring them into the world—as soon as you give security just watch the birthrate grow.[99]

B.C. Vital Statistics, tracking maternal deaths over those decades, support Mrs. Steeves' assertions. During the 1930s and 1940s the number of women dying as a result of abortions increased, not only as a percentage of maternal deaths but in actual numbers as well. There were more abortion deaths because more women wanted to end their pregnancies, and were having to seek them through illegal means involving unsanitary and dangerous methods.[100]

1941

The hormone Diethystilbestrol (DES) was brought onto the market as a miscarriage prevention therapy. There was no controlled testing prior to its release into general use. Subsequent tests warning of its ineffectiveness and possible risks were largely ignored. The drug was prescribed until 1971 for miscarriage and until 1978 for various other conditions. In 1971, DES would be linked with vaginal cancer in the daughters of women who took it while pregnant.

World War II Red Cross Workers

1941-42

Canada-wide, there were only 400 women practicing medicine as doctors.

Three communities received expanded health care resources. The VON began serving the Trail area, and the Sisters of Saint Ann opened Mount St. Mary's Hospital in Victoria as well as St. Martin's Hospital in Oliver.

1943

Dr. Agnes Black Weston Campbell became B.C.'s first public health doctor.[101]

The antibiotic penicillin came onto the market. Along with the sulpha drugs that had become available during the last decade, it was a powerful tool in controlling infections.

TB persisted as the fourth leading cause of death and a major cost in hospitalization. Treatment and prevention ate up the major share of the health budget. Mobile x-ray vans travelled the province, and

local public health nurses dropped everything when the vans arrived, in an effort to get everyone screened. The efforts paid off with a drop in the TB incidence rate by the end of this decade.[102]

1946

Dr. Ethlyn Trapp became the first woman president of the British Columbia Medical Association. She was the first woman in Canada to hold so high an office in organized medicine. During this decade, 47 women were added to the register of the B.C. College of Physicians and Surgeons. They began to locate outside the major centres. A greater proportion of female specialists was emerging as well.[103]

During the last half of this decade, the Red Cross expanded its outpost hospital program to nine more communities around the province. Public health nursing districts were created in Castlegar, Invermere, Burns Lake and the North Thompson.

1947

Venereal disease remained at epidemic proportions. The provincial government updated the *Venereal Diseases Suppression Act* allowing officials to detain infected persons for up to a year if they refused treatment. A Police Station Examination Centre was opened in Vancouver. Each morning all women in custody[104] were checked for infection, on the assumption that women were the source of infection.

Women and men of Chinese and South Asian origin were granted voting rights in B.C.

1948

The Hospital Insurance Act came into being in B.C. Initially paid for by monthly premiums and a $1 per day coinsurance during a hospital stay, it removed the inequalities previously associated with paying versus nonpaying patients. Designated physicians and interns

had previously cared for nonpaying patients instead of the patient's preferred doctor.

UBC opened its School of Medicine in unused army huts, pending construction of a permanent school.

1949

British Columbia began a pilot project offering a screening program for cervical cancer using the Papanicolaou (Pap) smear.[105] In this first year, 904 women were screened and nine cases of carcinoma were detected.[106]

Aboriginal and Japanese women and men were granted the right to vote in British Columbia.

Caring Through The Second World War

World War II brought women out to serve their country in force again. One physician who had interned at Vancouver General Hospital, **Surgeon Lt. Margaret Alexander,** was posted at a naval hospital in Eastern Canada.[107] She was one of only a few Canadian women physicians in the Armed Forces. Nurses served on every front, as they had during previous wars. Women also served through the Red Cross, bringing comfort to soldiers under severe conditions, as this excerpt from *The Victoria Colonist* of 1944 describes.

> ...When a hospital train or ambulance grinds to a stop in Italy or Normandy, Red Cross girls are there waiting. Often they have been curled in their sleeping bags along side the tracks putting in the long hours.[108]

Nursing Sister Ruth McIlrath was a prairie girl who took her nursing training in Winnipeg. When war broke out she volunteered for service and was posted in Nanaimo. An outbreak of mumps at the army training facility in Vernon took her to the interior. While there,

she received a phone call from Major Edna Rossiter, Principal Matron of the Pacific Command, asking her to serve aboard Canada's first hospital ship, the *Lady Nelson*. Ruth's closest friend, Nursing Sister Agnes Frazer, had agreed to serve if Ruth also went. The call came at noon, and Ruth was on a train by four o'clock that afternoon en route to her new assignment. The *Lady Nelson* was a converted cruise ship, but duty aboard her was no holiday. Ten nurses worked 12-hour shifts caring for up to 500 patients at a time. For security reasons, only the ship's captain was aware of their mission destinations. At first, they transported loads of injured soldiers from England to Canada, emptying the hospitals in preparation for D-day casualties. Then they were off to Africa or Italy bringing capacity loads of wounded back to England. After a six-month tour on the *Lady Nelson*, Ruth had several land postings in hospitals in England, Italy and Holland.

After the war, Ruth was telephoned again by Edna Rossiter with the offer of a position at Vancouver's Shaughnessy Hospital for Veterans. She accepted the position of Matron in 1947 and stayed with Shaughnessy Hospital for the remainder of her nursing career, retiring as Director of Nursing in 1976.

Now in her 80s, Ruth remains active in nursing and veterans' affairs. She has compiled a wealth of information on Canada's Nursing Sisters, and shares her knowledge through presentations and interviews. She is past president of the Nursing Sisters Association, served on the board of the George Darby care facility in Burnaby, and remains on the board of the Veteran's Manor in downtown Vancouver (a housing complex for hard to-house veterans). She spent a memorable summer combing Vancouver's Downtown Eastside searching for veterans living in dreadful conditions, hoping to convince them to move into the Manor. Many of these men owe their safe and dignified lifestyles to Ruth's courage and determination.[109]

Meanwhile, on the home front...

Despite the war, the population of B.C. increased by 42 per cent during the 1940s. Most of this population growth occurred outside the established centres, as people settled the northern and interior parts of the province. Expansion of the population, along with the loss of trained medical people to the war effort in Europe, made it mandatory to increase the ranks of the public health service. **Miss Heather Kilpatrick** became B.C.'s first Director of Public Health Nursing with a staff of 44 nurses province-wide. Among other duties, public health nurses relieved the pressure on the province's remaining doctors by taking responsibility for local immunization clinics. This marked the first time in Canada that nurses had actually given vaccinations rather than just prepared them for a doctor to administer.[110]

Often the only medical resource in small settlements, public health nurses were on call 24 hours a day at least six days a week. Although a car was usually provided, it was often not built to traverse the rough roads and weather conditions nurses worked their way through. It was routinely necessary to turn to horse teams, sleds and their own two feet to go where they were needed. Many courageous, self-reliant women filled these posts.

One example is **Nurse E.M. Claxton**, who in 1943 became the only medical resource in the Peace River block, stationed 21 miles north by stage from Fort St. John. She had total responsibility for Gough Memorial Hospital in Cecil Lake. As a Red Cross Outpost Hospital, this facility (which closed in 1953[111]) was the only medical link for the people of this remote wilderness area. Remembered as a soft-spoken little English woman with endless vitality, she covered a territory reaching 60 miles north of Fort St. John. The roads were poor all year round, and winter transportation was possible only by horse and sled.

Miss Claxton was deeply involved with the daily lives of the people of Cecil Lake. She started a Women's Institute and a children's animal protection group. Through correspondence with a benefactor in Victoria, she obtained books and other comforts for local residents. In fact, she became so attached to the people and the land of the North that when she died suddenly of influenza, it was her wish to be buried at Cecil Lake.[112]

The Fifties

1950

A national report on the roles of public health nurses and physicians had a great impact on service delivery in B.C. *The Baillie/Creelman Report* formulated many recommendations, including higher numbers of university trained nurses, supervisory training, clerical support, a move toward generalized health services provided through health centres, legalizing the giving of injections by nurses and improving salaries.[113]

Many of these recommendations came to fruition during the 1950s. Sixty community health centres were built with federal, provincial and local grants. Local service clubs, governments and various health agencies all contributed to the projects. Public health nurses were finally provided with facilities that allowed them to meet the needs of the community in functional and comfortable surroundings. The morale and community image of the public health nursing service received a big boost as well.[114]

In addition to the new facilities, working conditions for nurses improved. Their work week was reduced to five days, as they were no longer officially on call all weekend. District orientation programs helped new public health nurses fit into their new duties. Medical insurance and pensions became benefits. Clerical support workers were provided to reduce nurses' paperwork.[115]

The B.C. government introduced a bill guaranteeing that women receive pay equal to men's pay, for equal work. The new policy did not immediately filter down to the government health service. In advertisements for a training program for psychiatric nurses, the pay scale in the first six months saw women earning $113 per month while men earned $150.[116]

1955

Madeline Chung was registered as B.C.'s first Chinese-Canadian woman physician. Two sisters from Vancouver's Indo-Canadian community, both named **Kapoor-Siddoo,** became doctors during this decade as well.[117] The first graduates of UBC's medical school began appearing as registered physicians, but few were women. By the end of the decade, however, 111 new women doctors were added to the B.C. College of Physicians and Surgeons.[118]

The Salk vaccine provided protection from polio, which had reached an epidemic of panic level proportions. In this first year of its availability, public health nurses immunized 49,000 children. Estimates suggest that by the end of the decade more than 250,000 children under 19 years of age were immunized.[119]

1956

The success of the Cervical Screening Program over the previous five years prompted the province to expand the program, with the goal of reaching all B.C. women over 20 years of age. In this year, 15,106 women were screened and 85 cases of carcinoma were detected.

1957

The province's public health nurses numbered 191.

Nine per cent of Canadian medical students were women.[120]

Girls' Night Out!

The Dawning of Inclusion and Respect

By the close of the 1950s, women were an established fact in B.C.'s medical profession. Although they were still a small minority in comparison to their male colleagues, female physicians were growing in number and entering a broad range of specialties. At this time, women attending medical schools experienced less discrimination than had their pioneering grandmothers. In 1950, a newly graduated young doctor from UBC, who was one of eight women in a class of 150, remarked decisively about her classmates that "...there certainly was no prejudice from the men."[121] She had not yet begun her residency, however. Her opinion upon entering the day-to-day reality of hospital life may have changed. In 1958, one of her contemporaries, a skilled ophthalmologist, had 20 applications to hospitals rejected before she demanded to know why. She was advised that there were no changing or bathroom facilities for a woman physician; therefore, no possibility for employment. She assertively suggested she was quite happy to use the facilities in the nurses' residence and was hired.[122]

Assertiveness in claiming equal access for female physicians had its lighter side as well. By 1959, St. Paul's Hospital in Vancouver had six female physicians on staff and five female medical students. None of them was permitted to attend the annual staff physicians' dinner, however. This privilege was reserved for male physicians. The women decided enough was enough, and informed the hospital administration that if they could not attend the "men's dinner," they wanted to have one of their own. Permission was granted and the women planned a dinner at the William Tell, one of Vancouver's most exclusive restaurants, to be followed by an evening at the opera.

On the appointed evening, the 11 women assembled in their finery. Several of the students could not afford to buy evening wear and had borrowed or rented formal attire for the occasion. It is a well-known fact that medical students are chronically overworked, poor and hungry. The women physicians resolved to give the "poor dears" a good meal and proceeded to order everything on the menu, with appropriate selections from the wine list. Sampling each delicacy took longer than anticipated, leaving no time for dessert before the opera. The restaurant owner gladly accommodated the doctors' request to remain open for them after the performance. When the women returned, every "flaming" dessert on the menu stood in readiness, needing only the touch of a match to be ignited for their pleasure.

All in all the evening was grand; and so was the bill. The hospital administration paid more for the 11 women's first annual dinner than they did for the much larger men's evening. Alas, the first annual women's dinner was also the last. From that point on, the women were welcomed to join the men for one inclusive annual dinner. Their point had been made and their objective achieved. Never underestimate the power of a woman![123]

Caring Enough to Beat the Odds

The ranks of British Columbia's medical community have been enriched by many very fine women physicians. A few like Ethlyn Trapp, Lillian Fowler and Agnes Black Weston have been mentioned already. As women in a male-dominated profession, they were forced to fight for opportunities to take medical training, practice their skills, be accepted at meetings, deliver talks and even attend social functions. Being women, they were also forced to deal with family obligations in a field where devotion to the job was paramount. For some, the demands were too much, but many others remained undaunted and succeeded despite the odds. Here are brief glimpses at

but a few of the talented and determined women physicians practicing in British Columbia over this century.

Dr. Josephine Mallek came to Vancouver in 1941 with her husband Howard, who was also a physician. Howard was taken on staff at St. Paul's Hospital immediately, but Josephine fought the double discrimination of being not only a woman, but a Jewish one as well. Even today, she quips good-naturedly that she doesn't know how she ever got into medical school with the double quotas in place limiting both women and Jews. Her sense of humour and determination and the support of her husband sustained her. She eventually became the first woman physician taken on staff at St. Paul's Hospital.

The victory was bittersweet. Trained as an endocrinologist, she was initially denied the right to practice on the general medical wards and confined to obstetrics and gynaecology. After two years on staff, she was grudgingly granted permission to practice on the medical wards when it was recognized that her specialized knowledge was in regular demand.[124]

Josephine has been a great support to young women entering the field. She was a founding member of the Women's Medical Association, formed to provide moral support among female physicians, and was president of the Vancouver Medical Association from 1989 to 1991.[125]

Dr. Doris Kavanagh-Gray became the first female cardiologist at St. Paul's hospital in 1959, but not without considerable effort. Even obtaining her medical training was a challenge. She applied to the University of Ottawa Medical School right out of high school, at a time when returning World War II veterans took priority. She was told her request was out of the question, but she refused to accept this. Just 17 years old at the time, she approached the dean of the medical school, who was evidently impressed by this determined young woman. He told her the school was accepting two students right out of high school as an experiment. He chose Doris, and his

Dr. Josephine Mallek

experiment was a great success. She was one of two women accepted that year. She experienced no discrimination during her medical school years, but it was waiting farther down the road.

She married John Gray, also a medical student, one year before her graduation and gave birth to three children during their residencies in Detroit. Of those residency years, she remembers exhaustion and little else.

When her husband was offered a position at St. Paul's Hospital in Vancouver, they moved West. Doris applied to various hospitals, but received strange responses. One response questioned her having the strength to lift a patient, a task not generally required of a surgeon. Another advised that her expertise as a pediatric cardiologist was not required because there was no congenital heart disease in Vancouver. She would later be asked to tackle that hospital's four-year waiting list for pediatric cardiac care. Dr. Kavanagh-Gray went on to become the first woman Head of Cardiology at St. Paul's Hospital. Now retired, she remains very busy, her activities including heart-health education for women.[126]

Dr. Eileen Cambon experienced discrimination from the beginning and had to work very hard to prove herself worthy of acceptance to medical school. She obtained her Bachelor of Science degree from the University of New Brunswick, but when she applied for medical school, she was turned down in favour of several men with less impressive academic records. It took a Masters degree in biology and considerable persistence before she gained admission to McGill University as a medical student. Eileen was one of 7 women in a class of 110. Many of her classmates were returning veterans, one of whom she married while still at school. She and her husband were the first married couple in McGill history to graduate together. Residency and specialty training took them to the jungles of British New Guinea, London, England, and the United States before they settled in Vancouver in 1952.

As the first woman ophthalmologist in B.C. and the mother of two daughters, Eileen found it a challenge to build her practice. Like Dr. Kavanagh-Gray, she sent out many applications. Her male colleagues were helpful, and she eventually opened a clinic at Shaughnessy Hospital, working with war veterans and later with the public when Shaughnessy became a community hospital. Her affiliation there lasted 28 years. She also worked with B.C. Children's Hospital and joined its travelling clinic staff, treating children in the

northern part of the province. Eileen and her husband also provided clinics to residents of Terrace and Smithers at the invitation of the Alcan Company and local doctors, travelling at their own expense.

Retired from practice, Dr. Eileen Cambon remains active in the B.C. Branch of the Federation of Medical Women of Canada, having served as president and as an international representative.[127]

The Sixties

1963

Vancouver women participated in an 18-month study of a birth control pill that "...approaches the concept of the ideal contraceptive."[128] Conducted through the University of British Columbia, the study followed 117 women who took the pills for a combined 998 menstrual cycles with not one pregnancy reported. No serious side effects were observed during the study period. While doctors could not be certain of the effects when a woman stopped taking the pills, they believed it was unlikely that future fertility would be affected. The pill was made available by prescription, despite uncertainty on this matter.

1968

The provincial government instituted the B.C. Health Insurance Program, which consolidated various existing plans under one non-profit authority. Previously, private plans could not offer coverage to everyone on equal terms and conditions. Premiums varied according to income level, occupational risk factors, geographical location and so on. The new scheme met the conditions set out in the same year for federal cost-sharing of health insurance, which included comprehensive coverage, universal availability, portability and public administration.[129]

1969

Contraception was decriminalized nationally and abortion laws were relaxed somewhat. A woman seeking an abortion had to obtain the approval of a hospital-based Therapeutic Abortion Committee, which decided whether the pregnancy was a threat to her health or her life. Abortions were granted or denied on this basis. Access was

Pine Street Clinic

limited because, although no hospital was required to have a Therapeutic Abortion Committee, this was the only legal route available for terminating an unwanted pregnancy.

Caring through Demographic Upheaval

The decade of the 1960s was a time of tremendous change in the makeup of B.C.'s citizenry. The population increased by over 35 per cent to 2,000,000 people. Most of this increase was due to immigration. Another major demographic factor was the age distribution of the populace. "Baby boomers," all under 20 years of age, accounted for 40 per cent of the population. At the other end of the spectrum, the elderly accounted for 13 per cent of B.C. residents by the end of the decade, and this number was continuing to rise. Services at both ends of the life span required very specific skills, tasks and modes of

delivery that proved to be a sizable challenge to public health workers. During the 1960s, the ranks of the provincial public health nursing service grew from 222 to 342.[130] Public health nurses and women's groups were involved as advocates and planners of new programs, as well as being consumers of these new health initiatives.

Many members of the province's youthful majority were involved in a rebellion against the status quo. For young women, health issues involved venereal disease, pregnancy, single parenthood and malnutrition. Concerns over providing care for young people through this "hippie" era led to youth-oriented clinics such as Vancouver's Pine Street Youth Clinic. Originally housed in a trailer, the clinic provided a casual drop-in setting where young people could obtain advice and treatment in a nonjudgemental atmosphere. The clinic's success necessitated the addition of a second trailer and eventually a permanent location on West 8th Avenue.[131]

The growing number of elderly citizens led to the expansion of nursing and community-based services such as home nursing, Meals on Wheels and homemaker services. Senior centres provided recreational opportunities; screening clinics for hearing, vision and blood pressure; and nutrition and other health information. Women provided the majority of workers in this area of health care.

The Seventies

1970

It was April of this year before the relaxation of abortion laws became widely known. By July, 560 abortions were being performed monthly in B.C., and the total for 1970 was 2,906 abortions.[132]

1971

The Registered Nurses Association of B.C. (RNABC) released a position paper supporting further liberalization of abortion laws. While stating that abortion should not be considered preferable to other forms of birth control, the RNABC believed it should be a matter between a woman and her doctor. At the same time, the nurses called for more research into birth control methods, improved education and access to contraceptive information.[133]

A do-it-yourself pregnancy-testing kit appeared on drugstore shelves in this year. While not 100 per cent accurate, it enabled a woman to be "the first to know." It allowed her to consider her situation and seek early advice from her doctor.

The Vancouver School Board approved having birth control information available to students on request in city high schools. The decision was in response to the city's High School Students Birth Control Rights Committee[134]

The Dalkon Shield intrauterine device was introduced as a highly effective form of birth control. In reality, it was released onto the market with no reliable clinical tests and proved to be extremely harmful to the women who used it, causing severe infections that led to lowered fertility, hysterectomy and even death. The Vancouver Women's Health Collective became a local rallying point for B.C. women affected by the device.

1972

The Vancouver Women's Health Collective opened after two years in the planning. The collective began with a small group of women who were dissatisfied with the medical care they were receiving from their doctors. The aim was to empower women to take charge of their health care through education and by developing their own capabilities. Within a year, support had grown and they opened Canada's first women's self-help clinic. Services included providing a health information phone line, abortion counselling and referral services, health education groups, the women's self-help clinic and public presentations for community groups.

Today, the Vancouver Women's Health Collective operates out of an office shared with the B.C. Coalition of Abortion Clinics, the National Action Committee on the Status of Women and the Midwives Association of B.C.

The Health Collective's research contributed to the formation of the Women's Health Information Network, identifying the desire of women to have readily accessible health information. The Network is an information-sharing tool that publishes a newsletter four times a year and acts as a clearinghouse for woman-centered resources and organizations by providing information over the Internet.

Rosemary Brown became the first black woman elected to a Canadian legislative body. In her 15 years as a provincial MLA in British Columbia, she was a moving force behind funding for women's centres, Rape Relief, the Vancouver Women's Health Collective, postpartum counselling and transition houses.[135]

1974

The controversial *Foulkes Report* was released, outlining the proposed reconstruction of B.C.'s health care system. It called for increased public participation and awareness of health issues and increased efficiency within the system. There was a suggestion of

"one-stop" health services in a Community Human Resource and Health Centre.[136] The recommendations included making abortions and contraceptives available on demand.[137]

1976

The Campaign for the Legalization of Midwifery (CALM) was organized in B.C.

1977-78

The question of a woman's right to obtain an abortion reached another crescendo. Pro-abortion advocates pressured the government for abortion committees in every hospital, while anti-abortion groups lobbied for stricter controls. The memberships of hospital societies swelled as both sides in the debate attempted to stack board representation with members who supported their cause. Hospital board meetings became increasingly volatile. Health Minister Bob McClelland attempted to diffuse the tension at Vancouver General Hospital by cancelling the annual meeting of the hospital society and appointing a public trustee to replace the board.[138]

Women in Vancouver participated in the first "Take Back the Night Rally." This became an annual "women-only" event to demand an end to violence against women and the right of women to walk the streets alone in safety.

1979

B.C. continued to have the highest abortion rate in the country at 34.2 for every 100 live births and 21.2 for every 1,000 women between the ages of 15 and 44.[139]

Women's Health Movement

The women's health movement grew out of the second wave of feminism that began in the 1960s. The momentum of the women's liberation movement led to concerted efforts during this decade to achieve major advances in a woman's right to control decisions concerning her own body. To date, societal norms and expectations, formed predominantly by men, had dictated decisions that had a profound impact on women's lives. This was particularly true in matters concerning the female reproductive system, including birth control, abortion and cancer treatments as well as venereal disease control. The individual woman was left to cope with the consequences. One of today's strong advocates on women's health issues in B.C., **Robin Barnett**, reflected on the roots of the women's health movement:

> The women's health movement was (and is) always concerned with the social determinants of health—social determinants were always present in the philosophy and work of women activists in the community—they were not articulated as "social determinants," but understood as women's lives.[140]

Some of the social determinants that dictate our chances for success in all areas of life are our sex, age, ethnic background, physical and mental challenges, socio-economic class, education, sexual orientation and even whether we live in the city or a rural area. Each of these factors, among others, affects our ability to achieve and maintain good health. The women's health movement sought to empower all women to take control of their own health care and seek out health care providers that would support them in this.

Robin Barnett is an example of a woman who did just that. Robin has been a strong advocate of the women's health movement since the early 1980s. Exploring her own health concerns led her to the Vancouver Women's Health Collective and a new career focus.

Educated as a historian, she used her research skills to write *The Feminine Approach to Pap Tests.* Originally published as a booklet in 1983, it became a supplement to an issue of the women's magazine *Kinesis* and is now distributed internationally. Robin went on to spend seven years with BC Women's Hospital and Health Centre and is now a health consultant working on the Women's Health Planning Project for the Vancouver/Richmond Health Board. She also chairs the Canadian Women's Health Network, among other projects. Her particular focus is improving health resources for marginalized women.

The Eighties

1980

A report by the B.C. Cancer Control Agency found that since its province-wide inception in 1955, the cervical screening service had reduced the instance of cervical cancer in women over 20 years of age by 75 per cent. The mortality rate dropped by 66 per cent.[141]

An international conference on midwifery was held in Vancouver. Entitled "Midwifery is...a Labour of Love," the two days of meetings drew nurse midwives, apprentice-trained midwives, consumers and physicians together to work toward excellence in the practice of midwifery.[142]

1982

Amniocentesis, a test for detecting birth defects, was added to the services covered by the B.C. Medical Plan for expectant mothers 35 years of age and older.

1983

Grace Hospital began a Midwifery Pilot Project.

1984

A major study showed that DES mothers have a greatly enhanced chance of developing breast cancer.[143]

The first class of the B.C. School of Midwifery began. The school operated for six years and graduated 16 students from two programs, each three years in duration.

1988

The Screening Mammography Program of B.C. became the first of its kind in Canada. Initially a pilot program of the B.C. Cancer

Agency, it began with one site in Vancouver. Its goal was to provide annual screening and assessment to women over 40 years of age at no personal charge. Broadening of the service would be based on community interest, client demand and availability of funding from the Ministry of Health.[144]

The landmark Morgenthaler court case resulted in the striking down of *Section 251* of the *Criminal Code* and decriminalizing abortion in Canada.

Everywoman's Health Centre opened in Vancouver, providing reproductive health services including counselling and treatment related to birth control and sexually transmitted diseases, as well as first-trimester abortions.

Gender-Specific Research

As women continued to strive toward acknowledged equality with men, it became increasingly apparent that the very real differences needed to be acknowledged as well. In fact, women's very health depended on it. The field of medical research is an area where many of the differences have been overlooked. Symptoms that occurred in men were presumed to be the same in women. Medications and therapies considered effective for men were assumed to be the proper treatments for women.

It became increasingly clear, however, that women's symptoms and responses to treatment were different from those of men. Vancouver cardiologist Dr. Doris Kavanagh-Gray began to look for and identify these differences in her heart patients during the late 1970s and early 1980s. She discovered that the differences were huge. "Not only were there differences in the way disease presented itself in women, but in the way they were treated and how their medications reacted."[145] The more she looked, the more differences she found. She discovered that the differences were not simply physical. Women had

been socialized to put the needs of others first and did not lobby as aggressively on behalf of their own needs as they did for their families. For example, they accepted long surgical waiting lists for themselves but would fight against them on their husband's behalf. Even in the 1990s, although the differences were more generally acknowledged, many of the solutions remained elusive. For example, there is an increased incidence of women dying or developing complications from cardiac surgery, but we don't know why.[146]

Drug therapy presents another major area of difference between the sexes. Although women take more prescription drugs than men do, they have not traditionally been included in drug research trials. This was true even when the medications being developed were for specifically female conditions. Monthly cycles with the accompanying hormonal fluctuations made obtaining consistent data a complicated (and perhaps more expensive) exercise. Involving women in research during their fertile years also raised the moral issue of risk to an unborn child in the event of pregnancy during the test period. Drug testing was conducted on male animals and then on male human volunteers. When testing eventually did include women, they were tested only during the first part of their monthly cycle when hormone levels are low. Overlooked in this exercise of convenience was the fact that when women take these drugs, the impact of monthly hormonal fluctuations could be significant.

As Dr. Penny Ballem, Vice President of BC Women's Hospital and Health Centre remarked, "I think we don't know what we don't know."[147] Dr.Ballem and many of her colleagues are now trying to understand both the questions and the answers.

Women and Mental Health

Gender differences play a significant role in mental health. Women's mental health problems include depression, anxiety, borderline personality disorders and eating disorders. Social issues play a part in all these problems. Poverty, discrimination, violence, sexual assault and the multiple role expectations that society places on women all have an impact on mental and emotional well-being.

Gender also affects diagnosis and treatment. Eight per cent of B.C. women are diagnosed with depression, twice as many as in the male population. Women are also more likely than men to be diagnosed with borderline personality disorder. This illness involves self-destructive behaviours including suicide. Anxiety, panic disorders, post-traumatic stress and eating disorders are also common in women. Schizophrenia affects women and men equally, but the symptoms and time of onset may be very different. Serious mental illness is as prevalent in women as in men, but the differences in how the illness presents itself may inadvertently exclude women from treatment. Women are more likely to turn inward, making their problems less apparent. Men are more likely to behave in ways that involve them in the criminal justice system, making them appear to be in greater need of treatment.[148]

Research is under way in British Columbia through the Centre of Excellence for Women's Health to improve understanding of the genetic, psychological and social factors that affect women's mental health and the different ways in which women experience mental illness. A model of woman-centered mental health treatment is being developed.

The Nineties

1991

A $1.2-million provincial grant launched construction of BC Women's Hospital and Health Centre at the site of the former Shaughnessy Hospital in Vancouver. BC Women's opened in 1992 and became the first women-centered health care facility in the province.

A formal midwifery program was established at Grace Hospital with funds allocated specifically for this purpose. This was another first in the province. It became part of BC Women's in 1992. In the same year, a Royal Commission recommended that midwifery be legalized as an autonomous profession.

British Columbians wholeheartedly embraced the first annual "Run for the Cure." By the end of the decade, this national event became the country's largest single fund-raising event for research into finding a cure for breast cancer.

The increasing number of women with eating disorders prompted a Victoria doctor to organize the B.C. Eating Disorders Association.

1992

The Midwifery Association of B.C. applied to the Health Professions Council for legal recognition.

1993

The first B.C. Women's Health Conference was held in Vancouver, sponsored by the B.C. Ministry of Health. It brought together people with an interest and experience in women's health care to evaluate the present system, identify areas where change was needed and set priorities for action.

Violence against women of all ages is recognized as a major threat to their health. A Statistics Canada report entitled *The Violence Against Women Survey* revealed that one-quarter of Canadian women had been assaulted by their male partners and that one-third of Canadian women had been sexually assaulted. Almost one-quarter of young women between the ages of 18 and 24 had been attacked sexually while on a date. Fifty-nine per cent of B.C. women reported having experienced physical or sexual violence at least once in their lifetime. Thirty-six per cent reported having been assaulted by their spouses. One-third of girls in B.C. between grades seven and twelve had experienced sexual or physical abuse.[149]

Of the 477 new doctors registered in B.C. during this year, 199 were women.

1994

Following the recommendation of the Women's Health Conference, the provincial Ministry of Health created a Minister's Advisory Council on Women's Health. The council comprises 15 women from various regions, cultural groups and communities as well as government representatives. Its mandate is to advise the Minister on the health care needs of women and to develop policies and deliver health services that will ultimately achieve better health for the women of B.C.

Also created out of the Women's Health Conference was the Women's Health Bureau. Located within the Ministry of Health, its mandate is to promote a health care system that is sensitive to the needs of women by working within government and liaising with community groups and health care providers.

The provincial government approved draft regulations to establish a College of Midwifery. These regulations reserved the title "midwife" for those registered with the college. Under the new regulations midwives would be legally permitted to 1) provide prenatal

and postnatal care, 2) manage normal spontaneous vaginal deliveries, 3) assess, monitor and care for healthy babies, and 4) provide advice and support regarding infant care and provide some contraceptive services. The regulations acknowledged the uniqueness of aboriginal midwifery.[150]

1995

The B.C. government introduced the *Access to Abortion Services Act*, also known as "abortion bubble-zone legislation." The act created no-protest zones around abortion clinics as well as around doctors' offices and homes, recognizing a woman's right to hassle-free access to abortion services.[151]

The College of Midwives was established under the new regulations approved in 1994.

The Provincial Health Officer's Annual Report included a *Feature Report on Women's Health*. Among its findings were a number of statistics indicating how social determinants affect women's health. For example, women living in an urban centre can expect to live four years longer than women living in rural and northern communities. Aboriginal women live 12 years less on average than the total female population. Women working full-time earn 70 per cent of what men earn. Thirty per cent of households headed by women do not have suitable, adequate and affordable housing. Almost 60 per cent of B.C. women had experienced sexual or physical violence. The report identified a lack of adequate baseline information on women and mental health. Women were more likely to experience anxiety and depression than men, and suicide rates among women were five per 100,000. This figure jumped to 16 per 100,000 for Status Indian women.[152]

1996

The Centre of Excellence for Women's Health (CEWH) opened in Vancouver. The CEWH has a six-year mandate (1996-2002) to inform

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policy makers and add to the knowledge base regarding gender and the determinants of health.

A nationwide campaign was under way to raise awareness about the number-one killer of women in Canada. As a result of gender-specific research findings on cardiovascular diseases, the B.C. Heart and Stroke Foundation began a series of symposia to increase women's awareness of this disease, which kills eight times more women annually than breast cancer.[153] Over the next three years, these symposia increased from 3 to 24 per year. Previously considered a man's disease, research has found that cardiovascular disease presents itself differently in women and is even more deadly for them. Heart disease and stroke are responsible for 40 per cent of all deaths among women and 37 per cent among men.[154] Investigation continues into treatments that are more effective, taking into account differences in physiology and in the dynamics of the disease's manifestation in men and women.

1997

The Screening Mammography Program of B.C. (SMPBC) completed its first 10 years of service. Since its inception in 1988, the program had performed 895,849 screenings for 335,433 women. Abnormal screens were reported in 6.4 per cent and 3,246 cases of cancer were detected. Women 50 years of age and older accounted for almost 65 per cent of the service provided and for more than 82 per cent of the cancers found. B.C. women with breast cancer who had attended SMPBC were most often treated with breast-conserving surgery and less likely to require chemotherapy or tamoxifen. They were more likely to be alive and cancer-free at five and eight years after being diagnosed than women with breast cancer who had not attended the SMPBC.[155]

1998

As of January 1, the Ministry of Health announced the integration of publicly funded midwifery services in B.C. Midwives were registered with the College of Midwives of B.C., which set the standards for admission and practice along with assessment of their members' credentials. Hospital and planned home births would be funded for normal low-risk pregnancies. The *Home Birth Demonstration Project,* a two-year period of monitoring planned home births, was implemented. Its purpose was to integrate home births into the health care system safely and consistently. In making the announcement, B.C. became one of only two provinces to implement regulated midwifery, giving women more control over the type of care they preferred in a standardized and safe environment.[156]

Violence against women by men accounted for 48 per cent of all violent crime in Canada in this year. In B.C., 9,800 charges of spousal assault were laid and 81 per cent of the accused were male. Women are most at risk with men they know; 87 per cent of assault victims know their assailant and 46 per cent of assailants are the women's spouses.[157] The highest rate of violence reported by women anywhere in the country was in B.C. at 59 per cent.[158]

1999

The International Year of the Older Person provided a forum for addressing the issues facing older women. In B.C., several studies are under way examining nutrition, lifestyle-related factors, exercise and cultural and socio-economic issues.

Generally speaking, women live longer than men do. The average life span for women is about 81 years as opposed to 75 years for men. Older women make up 58 per cent of those over 65 and 72 per cent of people over 85.[159] This means women can expect to live a considerable portion of their latter years alone without the various supports a partner can provide. Statistics also indicate that senior women are less likely to live with family members than are senior men. In B.C., among those over 75 years of age, 51 per cent of women live alone compared to 21 per cent of men.[160]

It is also more difficult for women to be financially prepared to support themselves in their retirement years. The fact that a woman's employment income is approximately 73 per cent of a man's, and her working years are likely to be interrupted for child-rearing purposes, means there is less surplus income to earmark for retirement. In addition, women are less likely to have the option of pension coverage through their employers because of part-time employment, late workplace entry, and work interruptions.[161] As a result, their financial resources in later years may be limited. Recent statistics show that while 37 per cent of men 65 or over in B.C. have an income of $15,000 or less, approximately 60 per cent of women 65 or older have incomes at or below this level.[162] Nutritional food choices and the ability to prepare healthy meals depend on the ability to afford the ingredients and perhaps hire in-home assistance if you are unable to manage cooking alone. These factors have an enormous impact on women's quality of life and health. The type and location of a person's housing, nutrition, transportation options and recreational opportunities either enhance or hinder well-being.

Understandably, chronic and degenerative illnesses increase with age. Since women live longer, they are more likely to need medical attention for these conditions. Older women also experience mental health concerns such as depression, senility and pre-senile conditions that sometimes require hospitalization. Elder abuse has been identified as a significant threat to the health of older citizens. A national telephone survey conducted by Ryerson Polytechnical Institute in 1990 found that 40 of every 1,000 elderly Canadians living in their own homes had experienced some form of abuse. That is four per cent of the general population.[163] Alcohol abuse and misuse of prescription and over-the-counter drugs are issues for older women as well.

Six projects began this year, aimed at giving women the information they need to make choices about managing mid-life issues. *Women's Health in Mid-life Years* is a joint initiative of BC Women's Hospital and Health Centre, the Ministry of Health and the Health Association of B.C. The projects are being conducted at various locations around the province. The information gathered in these studies will be shared with women across the country.

The Challenge of Shaping Tomorrow's Care: Envisioning the Future

BC Women's Hospital and Health Centre

As the 1980s drew to a close and the '90s began to unfold, the need was becoming clear to acknowledge and address women's health needs as distinct from men's. Founded in 1991, BC Women's Hospital and Health Centre represents a major paradigm shift in addressing the health needs of the province's women. Its services combine a holistic approach to treatment with multidisciplinary research, community education and outreach. Located in Vancouver, it shares its site with BC Children's Hospital and is affiliated with the University of British Columbia. The combined resources of these three facilities provide a variety of programs aimed at attaining, promoting, and supporting the health of women of all ages, newborns and families throughout the province.

In 1996 a team from BC Women's Hospital and Health Centre published *BC Women's Community Consultation Report,* which identified BC Women's Hospital's role in addressing the health needs of women in B.C. The concerns raised by women and health care providers shaped the priorities BC Women's would address. These priorities included taking a leadership role in enhancing the delivery of women's health care through such initiatives as setting high standards of treatment, undertaking women-centered research, improving accessibility through increased awareness of diverse needs, allowing self-referral, and providing child care for patients and staff.

Today BC Women's is Canada's busiest maternity hospital, accommodating 7,500 births every year and employing more than 1,000 staff. Obstetrical services include a midwifery option as well as low-risk and special-care maternity programs. Childbirth constitutes only one aspect of BC Women's activities, however. A variety of outpatient programs serves more than 4,600 patients a year. Outpatient services include breast health, breast feeding, breast implant education and counselling, a residential and day treatment program for women with chemical addictions, maternity clinics, midwifery, osteoporosis, a program for women and children with HIV, Premenstrual Syndrome, reproductive health, abortion, contraceptive education, recurrent pregnancy loss, infertility, reproductive psychiatry, sexual assault and sexual health.[164] Many of these programs have expanded across the province. For example, the osteoporosis program, including exercise classes for senior women, is now active in 27 communities.[165]

The Centre for Excellence for Women's Health

The Centre for Excellence for Women's Health in Vancouver is one of five such centres across Canada. It has a six-year mandate (1996-2002) to inform policy makers and add to the knowledge base regarding gender and the determinants of health.

Projects now under way involve a seed grant program to facilitate multidisciplinary research into the barriers faced by women in society and how these affect their health. Issues such as socioeconomic status, race, culture, language, age, sexual orientation, geography, disability and addictions have always played major roles in the life chances of individuals and groups. Only in recent years have they been identified as determinants of health, and they are now being studied from a female-centered, action-oriented approach. Just a few of the areas of study involve woman-centered mental health care, the impact of health reform, eating disorders and the unique health needs of

marginalized women such as those living in isolated communities, lesbians and bisexuals, immigrants, aboriginal women, seniors and disabled women.

B.C.'s Centre of Excellence is fortunate to be under the direction of Dr. Penny Ballem, one of this country's most dynamic and informed leaders in the field of women's health.

Dr. Penny Ballem

Dr. Penny Ballem is one of the bright lights in the field of women's health today. As a vice president of BC Women's Hospital and Health Centre and principal investigator for the Centre of Excellence for Women's Health, she is perfectly placed to contribute her talents in directing research, education and community outreach in this field. Highly regarded as a specialist in the field of haematology, she is also a humanist with a positive, down-to-earth approach. Her life experience includes the challenges of single parenthood combined with the demands of a profession not sympathetic to family responsibilities. This combination of professional and personal understanding enables her to identify and address the concerns faced by women in many areas of life that inevitably affect their health.

According to Dr. Ballem, the importance of gender-specific research is not political correctness or power. As she points out, women are different right down to the molecular level, and their health needs cannot be adapted from studies of men. Women's life experience is different from men's, which also contributes to their state of health. However, she asserts that studying health from many perspectives is also of value to the entire population. The social factors that influence our health need to be integrated with the medical model to provide balance in detection, treatment and prevention. Dr. Ballem is particularly enthusiastic about the multidisciplinary research going on through the Centre of Excellence for Women's Health at BC Women's Hospital and Health Centre.

It's one of the first places where we've created an environment where people from different disciplines have come together effectively and talked and shared on an ongoing basis...bringing together people who would never historically have worked together and creating wonderful programs for the people who really need them...and we've done this in B.C.[166]

Dr. Penny Ballem

Facilitating the Vision

Women's Health Bureau

The New Democrat government created the Women's Health Bureau in 1994 in response to recommendations from the 1993 Women's Health Conference. The bureau's mandate is to develop effective women's health policies, advocate their health concerns and promote research into women's health issues.[16]

The bureau identified two important roles in the early years. One was championing causes and issues within government that the community had identified. The second was challenging individuals and interest groups to develop their ideas by consulting with them and providing them with small amounts of financial support.

Today the role of the Women's Health Bureau includes facilitating the development of self-sustaining programs and initiatives in the community. The stakeholders do much of the work themselves out in the communities. The bureau helps to build the framework on which these efforts can become self-sustaining. In the long run, this facilitation role will build more strength in representing women's health needs, says the bureau's director, Effie Henry.

We've always tried to spread the work out.... There are quite a few structures that support women's health in the province now. For longevity, spreading the work around is better than having one central group always doing the planning.

This philosophy is evident from the wide range of initiatives the bureau has undertaken and the broad base of support it has attracted. The bureau has forged successful partnerships with various departments in the Ministry of Health, the Minister's Advisory Council, the Health Association of B.C. and BC Women's

Hospital and Health Centre as well as with communities, stakeholders and professional groups. Six years into its mandate, the accomplishments of the Women's Health Bureau include:

- working on regulations and public funding for midwifery.
- the Abortion Services Access Act.
- producing and implementing the recommendations of "Realizing Choices"—a task force report on access to contraception and abortion services.
- creating the documents Provincial Health Goals for B.C. Women and Provincial Profile of Women's Health.
- building capacity in the regions and communities through a series of regional women's health planning conferences for health authorities, their staff and women-serving agencies.
- addressing women's health issues identified by the Minister's Advisory Council and other stakeholders, such as securing funding for a B.C. breast implant information centre, an outreach program for the health sector around violence against women, a review of prenatal screening in B.C., lesbian health, addictions, and women's health and mental health issues.

Minister's Advisory Council

The Women's Health Bureau also coordinates the Minister's Advisory Council on Women's Health (MAC). MAC was another recommendation from the 1993 Women's Health Conference. Formed in 1994, MAC comprises 15 women who represent different regions, cultural groups and communities, along with representatives from government and BC Women's Hospital and Health Centre. MAC's goal is to achieve better health for the women of B.C. Through collaborative relationships, feminist analysis, advocacy and a well-functioning council, MAC advises the Minister of Health on issues related to

women's health needs, the development of appropriate policy and the best methods of service delivery to the province's women.

Issues MAC has addressed include the medicalization of women's health, reproductive health, new reproductive technologies, midwifery, breast health and aboriginal women's health. Priorities for 2000 include regionalization of women's health services, women and violence, women and mental health, women and addiction, and lesbian health issues. MAC has also compiled major reports for the Minister of Health, including *Breast Cancer and B.C. Women (*1995), *Alcohol and other Drug Problems and B.C. Women* (1997) and *Moving Toward Change: Strengthening the Response of British Columbia's Health Care System to Violence Against Women* (1999).

Learning from the Past in Planning for the Future

Common themes run through the history of women and health care in British Columbia. From the beginning, women have been at the forefront of health care delivery. Their intelligence, courage and ingenuity have played, and continue to play, an invaluable role in the development and provision of health services. Women have been instrumental in identifying health and social issues that affect the health and well-being of the province's people. They have also overcome tremendous obstacles to achieve acknowledgement and acceptance as health care professionals and the right to control decisions concerning their own bodies as health care consumers. Despite women's involvement in the health care field, they were not involved in health care policy making.

Today, however, the exclusion of women from the ranks of professional medicine has given way to female representation across the broad spectrum of the health care field. A woman's desire to control the reproductive function of her own body and make her own decisions around parenthood no longer requires her to risk her life through a back-alley abortion, succumb to repeated pregnancies or break the law by using contraceptives. Medical researchers and practitioners now recognize that diagnosing illness and making assumptions about wellness based on the male model are inadequate for addressing female health issues. Medical research once excluded women from studies and trials and treated them with drugs developed for men, but now the research process requires female participation. Policy makers now recognize that although lesbian and bisexual women share many of the health issues of other women, they also have unique concerns of their own.

While encouraged by this progress, we must be careful not to rest on our accomplishments to date. We must use them as a basis for encouraging better understanding of, and broader involvement in, women's health issues.

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